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
	AL11969626	A. BUILDING: _____ B. WING _____	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRIVE AT FERN PARK	7255 STRIVE PL FERN PARK, FL 32730

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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: https://apps.ahca.myflorida.com/SingleSignOnPortal.	ZZ821		

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

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

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ZZ821	Continued From page 3 a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on 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 that resulted in a transfer to a hospital for 1 of 3 sampled residents (#12).	ZZ821		

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ZZ821	Continued From page 4 Findings: Resident #12's record showed a facility admission date of . A health assessment form (1823), dated , showed a medical history of 's . The form documented "ensure safety" and showed the resident needed supervision with ambulation and transferring. A facility incident report showed the resident was found lying on her on the common area floor on at 7 PM. A facility note documented the resident hit the side of her . The note showed the resident was transferred to a hospital and returned on at approximately 4 AM. A facility note, dated at 8 PM, documented a nurse was told on that day the resident was sent to a hospital on the previous night following a . No additional documentation further explaining the incident was provided. An 1823 form, dated , documented the resident was a risk and needed precautions. The form showed the resident needed assistance with ambulation and transferring. A facility note, dated at 3:36 PM, documented the resident returning from the hospital. A facility note documented the resident and hit her on at 8:30 PM and was sent to a hospital. An 1823 form, dated , documented the resident needed precautions. The form	ZZ821		

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ZZ821	Continued From page 5 showed the resident needed supervision with ambulation and transferring. A facility note, dated at 1:03 PM, documented the resident returning to the facility. The note documented that the resident was unsteady on her and required the use of a walker or wheelchair. A facility incident report documented that on at 9:20 PM, the resident was found sitting on the floor in a hallway. The report documented the resident complained of and within one hour complained of a . A facility incident report documented that on at 8:47 AM, the resident was found on her bathroom floor. A facility note, dated at 7:53 PM, documented a nurse was informed the resident was sent to a hospital after the on . A facility note, dated , documented the resident's family member reported the resident had a , and concussion. On at 3:05 PM, the Administrator said preliminary and full reports were not submitted each time the resident had a that resulted in a hospital visit because the facility could not have prevented the . The Administrator explained documentation was unavailable to show the facility's investigation to determine that. Unclassified	ZZ821		
A 000	Initial Comments	A 000		

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A 000	Continued From page 6 A re-licensure survey and a generator monitoring were conducted at Strive at Fern Park on and . Deficiencies were identified at the time of the survey.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon	A 008		

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A 008	Continued From page 7 request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel	A 008		

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A 008	Continued From page 8	A 008		

shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , . ,, . . require such assistance.

59A-36.006
(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection.
(a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following:
1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,
2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,
3. Any nursing or , , services required by the individual,
4. Any special diet required by the individual,
5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,
6. Whether the individual has signs or symptoms of ,
, , . . , . or any other communicable , which are likely to be transmitted to other residents or staff,
7. A statement on the day of the examination that, in the opinion of the examining health care

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A 008	Continued From page 9 practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted	A 008		

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A 008	Continued From page 10 through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish , , to be administered in the case of or , , . (f) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure a health assessment form (1823) was complete for 1 of 3 sampled residents (#5). Findings: Review of Resident #5's 1823 health assessment revealed the special precautions	A 008		

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A 008	Continued From page 11 section was blank. There was no documentation to indicate the facility contacted a health care provider to obtain the missing information. On at 3:57 PM, the Wellness Director stated after reviewing the form he doesn't have any. Further stating, he does not an updated 1823 and she did not contact the doctor to obtain a new one. On at 5:00 PM, the Administrator, Administrative Assistant, and Wellness Director confirmed the findings. (photographic evidence obtained) Class III	A 008		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of	A 010		

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A 010	Continued From page 12 appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended	A 010		

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A 010	Continued From page 13 congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued	A 010		

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A 010	Continued From page 14 residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a ˘ , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A ˛ ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of	A 010		

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A 010	Continued From page 15 placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 1 sampled resident (#4) who received hospice services had a care plan that specifies the services being provided by hospice and those being provided by the facility. Findings: Review of Resident #4's record revealed an admission date of . Review of the Health assessment form (1823) revealed Resident #4 received hospice services. The record did not have an Interdisciplinary care plan that specified the services being provided by Hospice and those being provided by the facility. During an interview on at 1:17 PM, the findings were discussed with the Wellness Director (WD), who said the document is in the Resident's record. The record contained Plan of care documentation; however, the record did not	A 010		

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A 010	Continued From page 16 contain an Interdisciplinary care plan. During an interview on at 2:02 PM, the WD provided additional Plan of care documentation and said she just received the documentation from Hospice. The documentation did not include an interdisciplinary care plan. During an interview on at 3:18 PM, the Administrator said Resident #4 started Hospice on . During an interview on at 3:20 PM, the Administrator was informed that Resident 4's interdisciplinary care plan with Hospice and the facility was not received. During an interview on at 3:30 PM, the WD provided Interdisciplinary care plan revisions and not the initial interdisciplinary care plan. The findings were discussed with the WD, who confirmed the findings. On at 4:18 PM, no additional documentation was received. (photographic evidence obtained) Class III	A 010		
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	A 025		

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A 025	Continued From page 17 such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, 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,	A 025		

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A 025	Continued From page 18 health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for with injuries for 1 of 3 sampled residents (#12). Findings: Resident #12's record showed a facility admission date of . A health assessment form (1823), dated , showed a medical history of 's . The form documented "ensure safety" and showed the resident needed supervision with ambulation and transferring. A facility incident report showed the resident was found lying on her on the common area floor on at 7 PM. A facility note documented the resident hit the side of her . The note showed the resident was transferred to a hospital and returned on at approximately 4 AM. A facility note, dated at 8 PM, documented a nurse was told on that day the resident was sent to a hospital on the previous	A 025		

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A 025	Continued From page 19 night following a . No additional documentation further explaining the incident was provided. An 1823 form, dated , documented the resident was a risk and needed precautions. The form showed the resident needed assistance with ambulation and transferring. A facility note, dated at 3:36 PM, documented the resident returning from the hospital. A facility note documented the resident and hit her on at 8:30 PM and was sent to a hospital. An 1823 form, dated , documented the resident needed precautions. The form showed the resident needed supervision with ambulation and transferring. A facility note, dated at 1:35 PM, showed the Wellness Director documented she informed the resident's family member that because the resident was extremely high risk, a risk assessment would be implemented upon the resident's return. A facility note, dated at 1:03 PM, documented the resident returning to the facility. The note documented that the resident was unsteady on her and required the use of a walker or wheelchair. A facility incident report documented that on at 9:20 PM, the resident was found sitting on the floor in a hallway. The report documented the resident complained of and within one hour complained of a .	A 025		

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A 025	Continued From page 20 A facility incident report documented that on at 8:47 AM, the resident was found on her bathroom floor. A facility note, dated at 7:53 PM, documented a nurse was informed the resident was sent to a hospital after the on . A facility note, dated , documented the resident's family member reported the resident had a , and concussion. The facility's mitigation policy, dated , documented that individualized care plans would be implemented for residents identified as a risk. The policy showed the care plan would be updated with preventive measures post- . On at 2:25 PM, the findings were discussed with the Wellness Director, who provided a comprehensive assessment tool and said it was the care plan. The assessment tool was dated and did not identify the resident as a risk and was not updated with preventive measures. On at 11:30 AM, Licensed Practical Nurse E said the resident had and was . The nurse said the resident lacked safety awareness and did not follow verbal instructions. The nurse said the resident's gait was slow and shuffled. The nurse said the resident walked around without help. The nurse explained the staff checked on the resident every two hours. Class II	A 025		

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A 032	Continued From page 21	A 032		
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 assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the	A 032		

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A 032	Continued From page 22 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 interview and record review, the facility failed to ensure 1 of 5 sampled staff (A) participated in a minimum of two resident elopement drills each year. Findings: Caregiver A's personnel record showed a hire date of . The facility's 2025 resident elopement drills showed the caregiver participated in one drill on .	A 032		

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A 032	Continued From page 23 On at 1:45 PM, the Administrator confirmed the findings. Class III	A 032		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (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	A 056		

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A 056	Continued From page 24 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 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:	A 056		

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A 056	Continued From page 25 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., 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 record reviews and interviews, the facility failed to ensure medications were refilled in a timely manner to ensure doses were not missed for 1 of 3 sampled residents who required assistance with self-administration of medications (#5). Findings: Review of Resident #5's 1823 health assessment revealed he required assistance with self-administration of medications and a medical history of , , . On at 10:05 AM, during an interview, Resident #5 stated the staff does not give him the same dose of medication each day and was unable to provide the name. Further stating, "I just know sometimes I get it and sometimes I don't." Review of his medication observation record revealed , - 30, , 5mg tab, take 1 tablet by once daily used for channel blockers was notated by staff with a	A 056		

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A 056	Continued From page 26 circle around their initials. Review of his medication observation record (MORs) revealed , - 6, , 5mg tab, take 1 tablet by once daily used for channel blockers was notated by staff with a circle around their initials. On at 2:12 PM, Unlicensed Caregiver A stated after review of the MORs the circled initials indicates the medication was not given. Further stating, the resident's medication was not available. She stated they tell the nurse who puts in the order for Resident #5 because he's VA (Veteran Affairs). Adding, the medication refill is usually put in 5 days in advance before running out. Further stating, it could take 5 -7 days or 7 -10 before the refill is received. The Unlicensed Caregiver stated Resident #5 is aware that he's out. On at 2:24 PM, the Wellness Director stated the resident has an outside doctor and goes to the VA. She said when he's running low, they contact the POA who orders the medication from the VA. She said the facility does not contact the VA. The Wellness Director was unable to provide any documentation to support contacting the POA. Adding, she did not document the call, and the facility does not have a medication refill policy. On at 3:19 PM, the POA was contacted via phone, stating no one from the facility contacted him about Resident #5 needing a refill for his , . Further stating, he needs that for his , . The POA stated that he will take care of it and get the meds refilled for the resident.	A 056		

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A 056	Continued From page 27 Review of a fax report dated from Orlando VA Medical Center for Resident #5, , 5 mg take 1 tablet by daily for 90 days with 2 refills. Review of his Residency Agreement date on page 13 stated the resident acknowledges that when medication re-order process takes longer than expected to receive the needed medications, Strive Assisted Living Facility will assist in obtaining the medication in a seven (7) day quantity from their preferred pharmacy. If there is not ample supply of medications within 72 hours of the last dose, the facility is authorized to order a seven-day supply from the preferred provider with costs being placed on upon the resident. Review of the facility's nurse daily task list indicated for Resident #5 - called VA for refill of , 5 mg tab, allow 10 days for delivery. On at 3:57 PM, the Wellness Director stated after reviewing the fax report, residency agreement, and nurse daily task list, The fax from the VA indicated he had a refill from , which covered 90 days. She said the nurse at the facility contacted the VA to request a refill, but it has not come in yet. Further stating after reviewing the residency agreement. She was not familiar with the agreement and unaware of the medication refill portion. She said the residents' POA only wants the medication refilled by the VA but was unable to provide any documentation to support they were not allowed to order from the facility's preferred pharmacy. The facility failed to ensure Resident #5's , was refilled timely, resulting in 10 days of missed doses by not honoring his residency agreement obtaining a 7-day supply	A 056		

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
	AL11969626	A. BUILDING: _____ B. WING _____	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRIVE AT FERN PARK	7255 STRIVE PL FERN PARK, FL 32730

(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 056	Continued From page 28 within 72 hours of the last dose. (photographic evidence obtained) Class III	A 056		