

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments An unannounced revisit to the Six Month Relicensure survey was conducted on _____ at Safe Harbor Assisted Living Resort. The facility had uncorrected deficiencies identified at the time of the survey.	{A 000}		
{A 030} SS=D	59A-36.007(6) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) 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 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	{A 030}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 030}	Continued From page 1 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 universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (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 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. (g) In addition to the requirements of section	{A 030}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/13/2020
NAME OF PROVIDER OR SUPPLIER SAFE HARBOR ASSISTED LIVING RESORT			STREET ADDRESS, CITY, STATE, ZIP CODE 1320 SW 26TH STREET FORT LAUDERDALE, FL 33315		
(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 030}	Continued From page 2 429.41(1)(k), F.S., the use of physical _____ by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical _____. 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 community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.	{A 030}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 030}	Continued From page 3 (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 mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for	{A 030}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020	
NAME OF PROVIDER OR SUPPLIER SAFE HARBOR ASSISTED LIVING RESORT		STREET ADDRESS, CITY, STATE, ZIP CODE 1320 SW 26TH STREET FORT LAUDERDALE, FL 33315		
(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 030}	Continued From page 4 relocation shall be set forth in writing. 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. (1) 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 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	{A 030}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 030}	Continued From page 5 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 incompetent or incompetent 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 provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted, private communication and unidentified telephone calls to residents. The facility also failed to ensure that residents have a clean and safe sleeping environment by providing a bed free of bodily waste for one resident (Resident# 13). The Findings Include:	{A 030}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/13/2020
NAME OF PROVIDER OR SUPPLIER SAFE HARBOR ASSISTED LIVING RESORT			STREET ADDRESS, CITY, STATE, ZIP CODE 1320 SW 26TH STREET FORT LAUDERDALE, FL 33315		
(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 030}	Continued From page 6 On a Revisit to a Six-Month Monitoring Visit Survey was conducted at the facility. During the visit this surveyor interviewed Administrator who stated that the only telephone in the building for resident access is in the office (which is on the outside of the facility). At the time of the survey, this surveyor observed that the telephone was broken and not operable. At 9:53 AM, this surveyor was working in the office next to the telephone, and dialed the number listed for the facility from separate private phone, heard no ring, and the call went to voicemail. During a confidential resident interview on between 10:38 AM - 10:47 AM, she stated they don't have a phone, so she can't call her sister. During interview with owner on she stated that there is someone in the office at all times, 24-hours a day. There is always someone in the office. So, if anyone wanted to use the phone, they could come in. This surveyor asked if the office door was locked at a certain time. She stated no. There is always someone in the office. This surveyor then asked if the one staff on duty at night had to leave at 12:00 midnight to do her rounds, is the office unlocked and accessible for residents to use the phone. She then stated, "At issue is that the phone is always broken, and everyday something is happening. So, we decided to put it in here. You know how much we spent on phones. States she is working on it, doing some renovations and will have one in the common area. The owner also stated that the phone residents use is not the office phone but has a different number. She picked up a cordless phone and dialed out. I asked where it is kept, she said in	{A 030}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 030}	Continued From page 7 here (office). This surveyor reminded her that a telephone must be accessible to residents and being locked in a separate office away from a common area accessed by residents does not meet the requirement. Additionally, during tour of facility on between 10:10 AM and 10:20 AM, this surveyor observed . . . # . The room has three beds with three residents. This surveyor observed that the bed located on the East wall was soiled and room smelled of During interview with the resident (Resident# 13) who was inside the room during this time, she stated she had an accident in the bed last night. Said she hasn't told anyone. On at 1:47 PM, this surveyor and Owner revisited . . . # . Inside room, this surveyor asked her to observe the room, which she did. She stated she did not see anything. This surveyor asked her to take a look at the bed located on the east wall belonging to Resident #13. She did and didn't observe anything. I asked her to look again, which she did. After observing that the bed was soiled with . . . , she stated she was going to be getting a new bed. This surveyor then asked if she didn't see that the bed was unmade and had . . . stains on it. She then said she would get with (Staff A) and see why. On at 1:56 PM, the owner came into the office where this surveyor was working. This surveyor inquired as to when staff does their cleaning as this surveyor observed they were cleaning rooms earlier. Specifically, if they had gone to that room. She stated yes, and that they have several employees that make rounds every 2 hours. This surveyor then stated that he had observed that the other beds had been made, but that one had not been.	{A 030}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
NAME OF PROVIDER OR SUPPLIER SAFE HARBOR ASSISTED LIVING RESORT		STREET ADDRESS, CITY, STATE, ZIP CODE 1320 SW 26TH STREET FORT LAUDERDALE, FL 33315		
(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 030}	Continued From page 8 On _____ at 2:05 PM Employee (Staff A) was brought into room as spoke with the owner. She stated that it (Resident# 13's bed) should have been changed by the night staff. "I tell them, but it's not made." States that when they went there this morning there was no access to the bed, she was there. Stated it's not a fresh wet. _____ at 2:41 PM, this surveyor met with Owner and Administrator to conduct Exit interview. Explained the findings, specifically the restricted access to a telephone for residents and the soiled bed for resident #1. They understood. The owner stated, they are going through a renovation and the items will be corrected, and that resident #13 will be getting a new bed. Class III	{A 030}		
{A 082} SS=D	59A-36.011(4) FAC Training - _____ / (4) _____. Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on _____, including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the	{A 082}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 082}	Continued From page 9 facility failed to ensure that 1 out of 4 sampled staff (Staff C) had completed training in / within 30 days of employment. Findings Include: On , a Revisit to a Six-Month Monitoring Visit Survey was conducted at the facility. During the visit this surveyor reviewed the facility's personnel file for Staff C. Observation revealed that the file contained no documentation verifying that the employee had completed the required / training. During interview with the owner and Administrator, this surveyor notified them that the documentation was not in the employee's file. The owner presented a certificate of the employees Control training. This surveyor advised that the training does not meet the requirement for / , for which the Administrator agreed. In addition, the Owner and Administrator was provided an opportunity to review the file, which they did. They also were unable to locate documentation that verified the employee had taken the training. On at 2:41 PM this surveyor met with Owner and Administrator to conduct Exit interview. Explained the findings, specifically the missing documentation that Staff C had received the required training in / . They acknowledged the findings and stated the employee would receive the training. Class III	{A 082}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 083} {A 083} SS=D	Continued From page 10 59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND (). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a staff member who has completed courses in First Aid and () and holds a currently valid card documenting completion of such courses is present in the facility at all times, for 1 of 4 sampled employee personnel files reviewed (Staff C). The findings Include: On a Revisit to a Six-Month Monitoring Visit Survey was conducted at the	{A 083} {A 083}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 083}	Continued From page 11 facility. During the visit this surveyor reviewed the facility file for employee (Staff C) and observed that it did not contain a current/valid certification that she was trained in First and . Staff C works 11:00 PM - 7:00 AM and experience working alone (only direct aide) during those hours. This surveyor interviewed the owner and Administrator on at 12:55 PM and informed them that the employee did not have a current /First Aid certificate. The owner and Administrator reviewed the file and was also unable to verification of the training/or certificate in the file. On at 2:41 PM, this surveyor met with Owner and Administrator to conduct Exit interview. Explained the findings, specifically the missing First Aid/ certification for Staff C. They acknowledged the findings and stated the employee would receive the training. Class III	{A 083}		
{A 152} SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own	{A 152}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 152}	Continued From page 12 belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable height to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, chest of drawers, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be soiled. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe living environment, free of hazards and ensure that all existing architectural, structural systems and appurtenances are maintained in good working order. The facility also failed to provide a dresser, chest of drawers, or other furniture designed for storage of clothing or personal effects. The facility also failed to provide a table or nightstand, bedside lamp or floor lamp. Findings Include:	{A 152}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 152}	Continued From page 13 On _____, a Revisit to a Six-Month Monitoring Visit Survey was conducted at the facility. During the visit, this surveyor toured the facility and observed the following: Room 2: During tour of the facility on _____ this surveyor observed room 2 and observed that there were several blinds missing from the window treatment. As such, residents of the room are not afforded complete privacy as visual access is possible from the outside. _____ : During tour of the facility this surveyor observed _____ and observed that there were no blinds at the west window. The walls were peeling and are discolored. Additionally, the North window had several blinds that were broken. _____ : During tour of the room on _____ this surveyor observed that the 5-drawer Chester-Drawer was missing the bottom drawer, the walls and baseboards were not clean and the walls had paint patches. This surveyor attempted to lift the window, and it only went up about 1/4 of the way. Bathroom between _____ : During tour of the facility between 10:10 AM and 10:30 AM, this surveyor observed the bathroom located between _____ . Observation revealed that the ceiling above the shower with black discolorations, and black spots throughout the ceiling. The sink cabinet had water stains and the wood has begun to crumble. There was also rust stains on the floor around the edges of the wall by the sink and around the toilette area. In addition, this surveyor did not observe a toilet paper holder.	{A 152}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 152}	Continued From page 14 During observation of , this surveyor observed that the baseboards had a water-like wear and mold-like substance. In addition, the and walls near the bottom had a foam-like substance between cracks in the brick. Observation of on by this surveyor revealed that several blinds were missing from the rail holding them. As such, residents of the room do not have complete privacy as visibility into the room is possible from the outside. In addition, all room walls and base boards were dirty and patches of paint missing from the walls and baseboards. Wall paint was still patchy and with scraps-offs. This surveyor also observed that there was no closet or apparatus available for resident to hang clothing. On between 10:38-10:47 AM, this surveyor observed # and observed an Armoire that is used by residents to keep their clothing. The employee accompanying this surveyor on the tour (Staff A) attempted to open the 2-bottom drawers and could not. Partial opening of the first drawer revealed that the drawer was empty. Resident 17 stated she uses the armoire to hang her clothes. States her roommate has her stuff organized (and pointed to rubber maid containers by bed). The ceiling in bathroom was observed to be cracked and appears ready to cave-in. During observation of on , this surveyor observed that the ceiling was cracked and has a moldy substance around the drywall casing around what appears to be/or was a vent in the ceiling. There was a lamp on a 4-tier Rubbermaid bin for bed 1. It also has a basket and plastic bin with had clothing stored in them. Bed 2 and 3 had a small 2-drawer	{A 152}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAFE HARBOR ASSISTED LIVING RESORT

**1320 SW 26TH STREET
FORT LAUDERDALE, FL 33315**

(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 152}	Continued From page 15 nightstand between it. Bed 2 had a broken dresser with clothing in it. Bed 3 had a dresser with drawers needing to be reset as they were hanging out from the main dresser frame. : On at between 10:54 AM - 11:05 AM. During observation of the room this surveyor observed that the floor was dirty. There were no window treatments (curtains, blinds, etc.), thus no possibility for privacy. The wall behind resident 14 bed had a big hole in it. In addition, the AC vents were clogged with dust and frame around it was made of plaster and cracking and had a water-like stains on it. Activity Room: During observation of the Activity Room at 11:18 AM, this surveyor observed that the door was scratched-up, the frame on the left-side is chipped, possibly from wheelchairs running into it. at 2:41 PM: This surveyor met with Owner and Administrator to conduct Exit interview. Explained the findings, specifically the physical plant issues identified. She acknowledged the findings and stated that a renovation plan is starting tomorrow. Stated the person/company performing the renovations got held up with a job but will be starting tomorrow and should take about 2 weeks. Class III	{A 152}		