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
	AL11968725	A. BUILDING: _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LIFE ASSISTED LIVING FACILITY	840 SW 8TH STREET POMPANO BEACH, FL 33060

(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 licensure Complaint survey, #2019017703, was conducted on . . . . . through at Green Life Assisted Living Facility. The facility had deficiencies at the time of the survey. Deficient practice was identified at a Class I for A 0025 and the facility was issued a Moratorium on Admissions on	A 000		
A 010 SS=D	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (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 shall be based upon an assessment of the strengths, needs, and preferences of the resident, 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. 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. (2) A physician, physician assistant, or nurse	A 010		

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A 010	Continued From page 1 practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A , ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 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 provider 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 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 residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (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	A 010		

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A 010	Continued From page 2	A 010		

plan of care issued by a health care provider,
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 provider, 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 a 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 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

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A 010	Continued From page 3 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 observation, interview and record review, it was determined that the facility failed to ensure that a resident's Health Assessment Agency for Health Care Administration (AHCA form 1823) was reflective and accurate of a resident's current care needs and diagnosis to ensure that a resident's care needs could be met by the facility, for 1 out of 3 sampled residents (Resident #3). The findings included: Review of Resident #3's record revealed an admission date of . . . . . Record review revealed the file contained two health assessments. One completed by the current facility and one completed by a prior Assisted Living Facility (ALF) in which Resident #3 resided (prior to coming to the current ALF). The Resident Health Assessment (AHCA form 1823) dated . . documented a diagnosis of . . . . . The . . . Status was noted as alert and oriented x 2. He required monitoring for daily rounds and reminders for important tasks. Both forms stated the resident required oversight daily for the resident's whereabouts, and wellbeing. A review of the prior AHCA 1823 form dated . . . . . , from the previous facility indicates a diagnosis of (, ,) with Memory Loss and suffers from . He requires daily oversight for his whereabouts, wellbeing, and reminders for important tasks. The current AHCA form 1823	A 010		

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A 010	Continued From page 4 dated . . . . . does not indicate the diagnosis of or . During an interview with the Director of Operations (DOO) on , it was revealed the resident routinely left the facility, freely walking within the community. Further record review revealed the facility had not assessed the resident's ability to in the community; as it relates to his care needs and diagnosis. Neither did the facility ensure the resident had identification on him at all times, for emergency purposes and/or if he had a while walking in the community. A review of the 1-day AHCA Adverse Incident Report, dated at 05:37 PM for Resident # 3 revealed, on at 04:30 PM, Resident # 3 advised Staff A, a Medication Technician (Med Tech) that he was going to visit his Sister. He also informed her that he once lived with his Sister. The Facility staff reached out to Resident # 1's Sister to follow-up on how resident #3 was doing, since they knew he did not take his medications with him. The Resident's Sister reported, she had not seen her brother. A search of local hospital's was immediately made, and a missing person's report was filed with law enforcement. The Primary Care Physician, Case Manager, and Home Health agency was then notified about resident #3 being a missing person. A review of the medical records was conducted for Resident # 3, the following was documented, Patient found on . . . . . in bushes by a bystander, shivering and shaking, and . . . . . Emergency Medical Services ( ) was called and the patient was brought to the Emergency Room (ER). While the patient was in route to Computed . . . (CT), the patient had a , ( ), and . . were administered. The Registered	A 010		

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A 010	Continued From page 5 Nurse (RN) at the bedside reported the patient awoke for a brief period and told them his name. Currently, the patient is unresponsive to nonverbal, did not follow commands or otherwise. The Patient was admitted for further evaluation and treatment. The admission diagnosis was noted as and . Resident #3 was discharged from the hospital on at 02:16 PM. The medications prescribed at discharge were 500 milligrams (mg) every 12 hours, ( ) Extended Release (ER) 100 mg three times daily. A review of Resident #3's record revealed, upon discharge from the hospital on , the facility failed to reassess the resident to determine whether resident #3 met the criteria for continued residency . The facility had not recommended Resident #3 for a new AHCA 1823 Form, for reassessment to add all of the resident's diagnoses to the form. The facility did not assess the resident's elopement risk and potential for . A reconciliation of the residents medications was not completed by the facility staff. A new plan of care and/or steps to prevent reoccurrence was not found in the residents records. On at 12:00 PM, an interview was conducted with the Administrator via telephone. He acknowledged the findings. Class III	A 010		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26	A 025		

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A 025	Continued From page 6 (7) The facility must 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 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	A 025		

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A 025	Continued From page 7 needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care and services and supervision appropriate to meet the needs of each resident within the facility, for 3 out of 3 sampled residents. As evidenced by the facility's failure to maintain adequate supervision for Resident # 2 who was observed smoking while wearing and utilizing an mask resulting in an explosion/fire and the resident suffered to the . For Resident #1 and #3, the facility failed to have knowledge of the general awareness of their whereabouts in which Resident # 1 away from the facility and was found in a car in a nearby apartment parking lot and Resident #3 away from the facility for 7 days and was found in the bushes by a bystander. Resident #3 was unresponsive and was labeled as "John Doe" for 3 days after being transfered to a local hospital. The findings included: A) A review of the facility's admission packet which included a smoking policy (undated) titled, "Smoking" revealed the following, Smoking is permitted within the designated smoking areas only. NO smoking is allowed inside the building, this includes resident apartments, common areas and bathrooms. Failure to follow this community policy may result in termination of Agreement.	A 025		

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A 025	Continued From page 8 A review of the Agency for Healthcare Administration (AHCA) Adverse Incident Report for Resident #2 completed on [redacted] at 03:09 PM by the Director of Operations (DOO) for Resident #2 revealed, on [redacted], Resident # 2 was sitting in the hallway leading to her bedroom (wearing her [redacted]) trying to smoke a cigarette, when it blew up in her [redacted]. Staff called 911 and Resident # 2 was taken to the hospital. The resident's Son was notified, a message was left for the Case Manager, Home Health Agency and her Primary Care Physician (PCP). No further details were documented about the incident. Further review revealed, there was no evidence of a corrective action, or summary initiated by the facility related to this incident. Review of Resident #2's observation notes revealed the following, on [redacted] at 4:59 PM, the Business Office Manager documented Staff G, a facility Medication Technician, heard a scream from the resident's hallway. When Staff opened the door to the hallway, she noticed that Resident #2's [redacted] tube was on fire. Staff quickly pulled the mask off and yelled for help. Multiple unidentified staff entered the scene. Staff called 911 reassured Resident # 2, that help was on the way. Multiple staff had witnessed Resident # 2 was smoking with her [redacted] canula tubing on her [redacted]. A review of the hospital medical records for Resident # 2 revealed on [redacted] at 5:02 PM, Resident # 2 was treated in the Emergency Room for [redacted] to the [redacted]. The Consultation Report dated [redacted], documented the patient was smoking her cigarette with [redacted] via [redacted] canula, the [redacted] caused the [redacted] to explode. The History and Physical (H & P) indicates the Patient	A 025		

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A 025	Continued From page 9 is a [redacted] with a history of smoking 2 packs of cigarettes per day and [redacted]. The Patient was smoking today with her home [redacted] when the [redacted] burst into flames in her [redacted] while smoking. The Patient notes there was a brief flash flame in her [redacted], while she was smoking with her [redacted] on. The patient presented in the Emergency Room (ER) with a level 1 [redacted], with [redacted] around the [redacted] and [redacted]. The Resident treated in the ER for [redacted], and [redacted] and discharged from the ER at 8:08 PM on [redacted]. An additional observation note was entered by Staff I, a facility Medication Technician, who works on the 11:00 PM - 7:00 AM shift. Staff I documented, the following additional incident that occurred on [redacted] at 2:16 AM. Resident # 24 came to tell me that Resident # 2's "[redacted] thing" (that gives [redacted]), set a small fire. When Staff I arrived, the floor was covered in black and her [redacted] canula was burnt off her [redacted] again. The Resident yelled, "I'm not going to the hospital." I called the Director of Operations (DOO), and she was notified. Record review revealed, Staff K, a Medication Technician who worked on the 7:00am -3:00pm shift documented, on [redacted] at 08:30 AM, the Resident complained of not breathing properly. The staff called 911 and the resident was reassured that help was on the way. The Resident was transported to the hospital with [redacted] on. The Resident's Son, and Case Manager were notified. The exact time of the notification could not be determined due to a lack of documentation and investigation by the facility. Review of the hospital records for Resident #2	A 025		

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A 025	Continued From page 10 dated [redacted] at 8:27 AM revealed, Resident #2 was transfered to the hospital. The patient presented with difficulty breathing. The course/duration of symptoms was a history of [redacted] a patient who reports her [redacted] ran out last night and progressively throughout the night her [redacted] worsened. Also, has a [redacted] from 1 weeek ago when she was smoking and ignited her [redacted]. She is being treated with [redacted] creams for her [redacted]. The resident was discharged [redacted] to the facility on [redacted] and a few hours later the facility initiated a [redacted] for Resident #2 due to her continuous smoking while using her [redacted]. The resident was then transferred to a [redacted] facility by the appropriate parties. On [redacted] at 1:14 PM, interviews were conducted with direct care Staff A and D, they indicated that they had witnessed Resident # 2 smoking, while wearing her [redacted]. They stated they had previously informed Administration of their observations, prior to the [redacted] incidents. On [redacted] at 02:25 PM, an interview was conducted with the DOO. She stated the resident was observed smoking while wearing the [redacted] on [redacted]. She stated, she issued a verbal warning to the resident and then issued a 45-day discharge notice effective date [redacted]. She stated, Resident # 2, returned from the hospital on [redacted]. She stated, resident #2 was educated on [redacted] about smoking in her room only. She stated Resident # 2 was not interested in the information. The DOO further stated that Resident # 2 was [redacted] for smoking again in the room on [redacted] after returning from the hospital on [redacted]. She identified the significant change was when the	A 025		

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A 025	Continued From page 11 . . . order went from an as needed (prn) basis to a continuous (24-hour) . . order. However, the facility was unable to produce any documentation of a new assessment of Resident #2s new care needs or risk of her smoking while using . . ; as the resident had a history of smoking. On . . . . . at 2:25 PM, a request was made to the DOO to provide a plan of care for Resident # 2 that the facility implemented to reduce her risk of being and prevent future occurrences. The DOO provided the 45-day discharge notice for Resident #2 that was dated . The notice was signed by the resident and the DOO. A request was made for the policy on Supervision, however, the policy was not provided. The facility was unable to demonstrate any interventions and/or actions implemented to appropriately supervise Resident #2 due to her being at risk for . . due to smoking while using . . . On at 10:05 AM, an interview was conducted with the Marketing Director. She stated that she assists the DOO with overseeing the resident's wellbeing and their daily care. She stated the residents are verbally advised that they should only smoke under the new canopies in the courtyard. She stated they did everything to help Resident # 2 stop smoking, but she was not . She stated, she offered a vaping device, but the Resident refused. She stated, she also told the staff to keep an . on Resident #2. But, no specific directions or supervision orders were provided to the staff. On at 1:14 PM, an interview was conducted with direct care Staff A. She stated she has seen Resident #2 smoking with the . .	A 025		

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A 025	Continued From page 12 lots of times. She reported, she has caught her and told her not to do so. She stated, she has begged resident #2 to stop smoking. On at 3:35 PM, an interview was conducted with direct care Staff H. She stated she saw Resident # 2 smoke in her room on numerous occasions. She stated, one time she caught her at night smoking by the vending machine. She reported, on that same night the 2nd incident occurred. She stated, she had told the DOO and the , that Resident # 2 never cooperates. On at 4:25 PM, an interview was conducted with Staff F, a medication technician and cook. Staff F reported, she knew Resident # 2 was always smoking with the . She reported, she had verbally informed the Administration on numerous occassions. On and , between the hours of 9:30 AM and 2 PM, residents were observed smoking in various non-designated smoking areas. Staff members were not observed redirected the smokers to the designated smoking areas. Review of Resident #2's file revealed an admission date on or around . Resident #2's current Health Assessment AHCA form 1823 was completed on and documented diagnoses of difficulty walking, , , , , , ( ), and , . She had an unsteady gait and used a wheelchair for assistance. She has an order for continuous and is a smoker. She is identified as a Limited Mental Health (LMH) resident. The AHCA form	A 025		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 13 1823 further documented the resident requires daily oversight in daily rounds for the resident's whereabouts, reminders for important tasks and wellbeing. Resident #2 requires supervision with bathing and transferring. The Physician documented her Status as "[illegible]" A review of Resident #2's Physician Order dated for use noted 2 liters of continuous; check saturation twice weekly; Home Health Aide 2 x weekly for assistance with Activities of Daily Living (ADL) care; and Nurse for and [illegible]. Resident #2's file revealed the resident has a history of smoking at least 2 packs per day. Review of Resident #2's file failed to indicate any assessments completed with respect to the residents smoking and using to ensure a safe smoking environment. There was no documentation of interventions implemented by the facility after being notified on numerous occasions by staff about Resident #2s smoking while using . The facility also failed to assess the risk of Resident #2s smoking in the facility and the potential fire risk for the safety and wellbeing of other residents residing in the facility. On [illegible] at 4:32 PM, an interview was conducted with Resident # 2's son, the following was revealed. He stated Resident # 2 suffers from and the use is new. He reported, the resident has trouble breathing at night and must go looking for staff to assist her. He stated he has concerns about Resident # 2 not having access to a call button in her room. He stated the Nurse from the facility did not notify him of the first until 2 days later on	A 025		

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	AL11968725	A. BUILDING: _____ B. WING _____	02/05/2020

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A 025	Continued From page 14 . . . . . He stated, resident #2 had been expecting to get a patch, but they never provided one. He stated, when Resident # 2 was the second time the facility waited a long time before they sent her to the hospital. He stated, the facility did not explain to him, why Resident # 2 was . . . . . at the facility. He reported, they just told him that she must leave the facility. B) Review of Resident #3's record revealed an admission date of . Record review revealed the file contained two health assessments. One completed by the current facility and one completed by a prior Assisted Living Facility (ALF) in which Resident #3 resided (prior to coming to the current ALF). The Residents Health Assessment (AHCA form 1823) dated . . . . . documented a diagnosis of , . The Status was noted as alert and oriented x 2. He required monitoring for daily rounds and reminders for important tasks. Both forms stated the resident required oversight daily for the resident's whereabouts, and wellbeing. A review of the prior AHCA 1823 form dated , from the previous facility indicates a diagnosis of (, ,) with Memory Loss and suffers from a . . . . . He requires daily oversight for his whereabouts, wellbeing, and reminders for important tasks. The current AHCA form 1823 dated does not indicate the diagnosis of or . . . . . During an interview with the Director of Operations (DOO) on . . . . . , it was revealed the resident routinely left the facility, freely walking within the community. Further record review revealed the facility had not assessed the resident's ability to in the community; as it relates to his care needs and diagnosis. Neither did the facility	A 025		

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A 025	Continued From page 15 ensure the resident had identification on him at all times, for emergency purposes and/or if he had a [redacted] while walking in the community. A review of the 1-day AHCA Adverse Incident Report, dated [redacted] at 05:37 PM for Resident # 3 revealed, on [redacted] at 04:30 PM, Resident # 3 advised Staff A, a Medication Technician (Med Tech) that he was going to visit his Sister. He also informed her that he once lived with his Sister. The Facility staff reached out to Resident # 1's Sister to follow-up on how resident #3 was doing, since they knew he did not take his medications with him. The Resident's Sister reported, she had not seen her brother. A search of local hospital's was immediately made, and a missing person's report was filed with law enforcement. The Primary Care Physician, Case Manager, and Home Health agency was then notified about resident #3 being a missing person. On [redacted] at 10:55 AM, an interview was conducted with the DOO. She was asked if the Sister of Resident # 3 was contacted prior to allowing the Resident to leave on the noted date. She stated Resident #3's Sister advised the Management Staff, when he was admitted that she didn't want anything to do with the resident. The DOO stated, she was not present in the facility at the time the resident left. The DOO further stated that she had not informed any staff regarding the sister's concerns and wishes voiced to her, neither had she informed staff that Resident #3 was not to visit his sister. During an interview on [redacted] at 12:30 PM with the DOO, it was revealed that Resident #3 routinely left the facility and walked throughout the community, not signing in or out on the facility's sign-in/sign-out log. Although, this was a	A 025		

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A 025	Continued From page 16	A 025		

pattern for Resident #3, the facility never intervened to ensure appropriate supervision was provided to the resident, especially since the resident suffered from and required supervision.

During a telephone interview with the Administrator on at 4:30 PM, the Administrator, stated that he was actively seeking an apartment near the facility, so that he could devote more time conducting the day-to-day activities at the facility. He refuted the allegations of an elopement. He expressed that the facility's policy is not to admit any resident's deemed as or an elopement risk. The Administrator did acknowledge the facility should have made a diligent effort with the coordination of care for Resident # 3.

On at 2:20 PM, a telephone interview was conducted with the sister of Resident # 3, where she disclosed that the facility contacted her only after Resident #3 was missing for 7 days. She stated that she lives 156.6 miles away from the facility (2 hours and 27 minutes via vehicle). She stated the facility called her to see how he was doing at her home; and she informed the DOO that she had not spoken or seen her brother for some time. She also clarified that the facility did not contact her for permission to allow her brother to visit her. She further explained that her brother is not to visit her due to a prior violent incident exhibited by Resident #3 against her. During a further interview, the sister stated that she posted a missing person's report on social media, and a nurse from the hospital then reached out to her and informed her that Resident #3 was in the ( ) for 3 days as a John Doe. The nurse stated that prior to the sister's post on social media, she was

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A 025	Continued From page 17 in the process of contacting the police to obtain his , for identification purposes because he was non-verbal. The sister also disclosed that he suffers from and ; and when he has , he loses his function for eating and talking; he is like a victim. She went on to say this is the reason why he is living in an Assisted Living Facility (ALF), because he needs supervision. She reported, she has Power-of-Attorney/Health Care Surrogacy (POA/HCS) rights for Resident #3 and should have been contacted. A review of the hospital medical records was conducted for Resident # 3, the following was documented, Patient found on in bushes by a bystander, shivering and shaking, and Emergency Medical Services ( ) was called and the patient was brought to the Emergency Room (ER). Resident #3 was admitted into the hospital on at 12:29 PM. He was admitted as "John Doe". While the patient was in route to a Computed , (CT) Scan, the patient had a , ( ), and , were administered. The Registered Nurse (RN) at the bedside reported the patient awoke for a brief period and told them his name. Currently, the patient is ranging from being unresponsive to nonverbal, did not follow commands or otherwise. The Patient was admitted for further evaluation and treatment. The admission diagnosis was noted as , , , and Resident #3 was discharged from the hospital on at 02:16 PM. The medications prescribed at discharge were (an) 500 milligrams (mg) every 12 hours, { , an) Extended Release (ER) 100	A 025		

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A 025	Continued From page 18 mg three times daily. A review of Resident #3's record revealed, upon discharge from the hospital on , the facility had not recommended Resident #3 for a new AHCA 1823 Form, for reassessment to add all of the resident's diagnoses to the form. The facility did not assess the resident's elopement risk and potential for . A reconciliation of the residents medications was not completed by the facility staff. A new plan of care and/or steps to prevent reoccurrence was not found in the residents records. C) A review of Resident #1's Florida Health Assessment Agency for Health Care Administration (AHCA 1823 Form) revealed that Resident # 1 was admitted into the facility on or around . The AHCA 1823 form was dated . The form notes the resident suffers from the following diagnoses; Spasms, Abnormal Gait, , and . It also notes the resident is alert and oriented x 1 (Only to person); and received Nursing. She is identified as a Limited Mental Health resident. Further review of the form revealed the resident required monitoring for daily rounds and reminders for important tasks. The form also documents the resident requires oversight daily for her whereabouts, and well-being. The resident required supervision with ambulation, bathing, , self-care grooming and was independent with eating, toileting, and transferring. A review of the Agency for Health Care Administration (AHCA) 1-day Adverse Incident Form for Resident #1 was conducted. The form	A 025		

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A 025	Continued From page 19	A 025		

indicated that the Director of Operations (DOO) completed the 1-day Adverse Incident Forms on [redacted] at 7:44 PM. The following statement was written by the DOO at 7:15 PM: Staff B, a Medication Technician on the 3:00 PM - 11:00 PM shift called to inform that the police was at the facility inquiring about Resident # 1. This writer reiterated to staff that Resident # 1 was at the local hospital, but staff informed the DOO that the police was aware of this information but continued to investigate, as a female matching Resident # 1s description was found [redacted] in a car next to our facility. Upon hearing this, this writer immediately went to the Hospital and upon investigation found out that the patient there that had the same name was not a resident of the facility. The names were similar, but not the same. This writer immediately returned to the facility and met with detectives and the medical examiner who confirmed after looking at a picture of Resident # 1 that the [redacted] female is our resident. The Medical Examiner also added that she [redacted] of natural cause. On Monday, [redacted] at about 4:00 PM this writer spoke with a Detective who confirmed that the [redacted] female was in fact our resident.

On [redacted] at 10:30 AM, an interview was conducted with the Marketing Director. She stated on [redacted] at approximately 3:45 PM, a staff member on the 03:00 PM - 11:00 PM shift, notified her and the Director of Operations (DOO) that Resident # 1 was noted missing when she conducted her evening rounds. She stated to search for Resident #1, she walked behind the church near the facility and the DOO drove up the Boulevard. She stated she checked into the nearby convenience store. She confirmed that she was on her way into work when she last saw Resident #1 at approximately 10:00 AM; she

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A 025	Continued From page 20	A 025		

stated she spoke to Resident # 1 at that time. She stated Resident # 1 told her that she was going to the park to feed the squirrels. She confirmed that she did not require the resident sign out on the log book, which is the facility's policy, nor did she sign out for the resident to stamp the time of departure. She stated, she didn't think to do it, since this is the resident's normal routine. She confirmed, she did not notify the Administrative Staff that Resident # 1 missed lunch at 12:00 PM. She reported, it was routine for Resident # 1 to go to the park.

On at 10:55 AM, an interview was conducted with the Director of Operations (DOO). She stated on at 3:45 PM, she was in the facility when the staff made them aware that Resident # 1 was missing. She stated, she made notifications to the local law enforcement, and the nearby area hospitals to search for the resident. She confirmed that she also drove up the road to the Boulevard. She stated she did not contact any authorized representatives, because the two names listed on the demographic forms were her parents and they had been . . . . . for approximately a year. She stated, Resident # 1 did not have any family. The DOO stated that she called the local Emergency Room (ER) department, the time was unknown and spoke with a Nurse. She stated, she asked the Nurse if Resident # 1 was in the ER. The Nurse informed her that she had a patient by the name of [Resident # 1]. She stated, she failed to verify the date of birth for Resident # 1 with the Nurse or any other identification to confirm the true identity of the resident. She was told the resident with a similar name was in the ER at the hospital. She stated that she did not conduct a -to- interview or observation to ensure that this was the correct resident. She stated she did not think

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A 025	Continued From page 21 it was necessary at the time. She stated she called off the missing person search at that point, the exact time was unknown. She admitted that she was not aware that she needed to conduct an internal investigation. During a telephone interview with the Administrator on at 4:30 PM, The Administrator, stated that he was actively seeking an apartment near the facility, so that he could devote more time conducting the day-to-day activities at the facility. He refuted the allegations of an elopement. He expressed that the facility's policy is not to admit any resident's deemed as or an elopement risk. He stated they did everything they could do in the case of Resident # 1. However, the facility was not able to provide any evidence of an investigation regarding Resident #1's elopement/ resulting in the resident not returning to the facility and being found in a car nearby. On at 11:45 AM, an interview was conducted with the Med Tech (Staff B), she confirmed that she was on duty at the time of the incident of Resident #1. She stated, she looked around the park and looked around the facility at approximately 4:30 PM on . She stated she could not locate Resident # 1. She went on to confirm that she notified the DOO on at approximately 7:15 PM, when the police came to the facility. On at 12:15 PM, a telephone interview was conducted with the Supervisor for the Case Manager for Limited Mental Health (LMH) for Resident # 1. Resident # 1 was identified as an LMH resident. He stated their records indicated the facility never called to notify them of the missing person and/or of	A 025		

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A 025	Continued From page 22 Resident # 1 in . . . . . He stated they did receive a call from the facility on . On at 1:19 PM, an interview was conducted with the Detective assigned to the criminal investigation of Resident # 1. He stated on . . . . . (the time was unknown), a call was placed to 911 by a male who lives in an adjacent apartment . . , . near the facility. He stated, the Deputy interviewed the male. He stated the male advised him that he was unable to lock the doors on his car because the locks are broken. He stated the male stated, when he came out to his car; he found a female lying on the . . . seat of his car . . . . . He stated the male stated he immediately called police. He stated the Deputy went to the facility to ask if the female found in the seat of the car was Resident # 1. The Deputy tried to pull her name up in the Department of Motor Vehicles because she didn't have any Identification (ID) on her person. The DOO went to the office and confirmed that it was Resident # 1. They were told by the facility that Resident #1 can come and go as she pleases. He stated he notified the resident's Niece. He indicated that the Resident was found damp, so she possibly went into the car to get out of the rain. He stated based on the review of the 911 call system, they did not receive a prior call from the facility for a missing- persons report on . . . . . regarding Resident #1. A review of the local Medical Examiner Report dated at 9:29 AM documented the circumstances of . . . . noted as, the decedent has a history of mental illness. She was found unresponsive in the . . . seat of a stranger's car when he opened the car doors in the morning. The decedent is received clad in an adult diaper, a beige sweater, an orange shirt, black and white	A 025		

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A 025	Continued From page 23	A 025		

pants, a long-sleeved gray and white sweater and an orange shirt. There is no evidence of recent injury. Opinion: The female, Resident # 1 . . . as a result of Hypertensive and . . . . . .

A review of the online weather channel revealed the temperature for the following date of . . . . . , recalled a high of 85 degrees with lows of 72 degrees Fahrenheit.

On at 4:00 PM, an observation was made of the adjacent park and the apartment , . There was a heavy flow of traffic observed in these areas. The proximity to both areas were in excess of 50 from the facility.

A review of the Sign In/Out Logs revealed a lack of evidence that Resident #1 left the facility on . An observation of the Sign Out Log #1 was conducted on . . . . . at 3:00 PM. The Log was in the dining room on a table underneath the wall-mounted Television (TV) unattended and not monitored by Staff. An observation was made of Sign Out Log #2, which was on the desk of the Receptionist located in the Administrative Office. The Surveyor was advised by the DOO during the observation, the office hours were from 9:00 AM - 5:00 PM, for residents to sign in/out.

A review of the Daily Log Note revealed documentations was entered by the DOO on at 4:46 PM, detailing the aforementioned sequence of events, outlined in the 1 Day Adverse Incident Report for Resident #1. The following additional information was found in the progress notes for Resident #1. Staff members noticed Resident # 1 was missing after doing their rounds on the second shift; at that

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A 025	Continued From page 24 time a missing person alert was called in. All responsible parties including the Primary Care Physician, and [redacted] Nurse were notified. A review of the 15-day Adverse Incident Report for Resident # 1 revealed a completion date of [redacted] at 11:04 AM. The Corrective Action Summary written by the DOO documented, Staff has been placed on high alert and has been encouraged to be more vigilant. We are also trying to be more involved in order to try to get residents to open up more and try to talk to me and staff. It is unclear if or how this plan of correction was implemented. The Administrative Staff failed to provide evidence of their investigation to devise their corrective action plan. Class I	A 025		
AL241 SS=D	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the [redacted] agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the [redacted] agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that	AL241		

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AL241	Continued From page 25 has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a , agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager. 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving	AL241		

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	AL11968725	A. BUILDING: _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LIFE ASSISTED LIVING FACILITY	840 SW 8TH STREET POMPANO BEACH, FL 33060

(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
AL241	Continued From page 26 social security , or supplemental security income and as follows: a. An affirmative statement on the Alternate Care Certification for ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-03988, that the resident is receiving SSI or SSDI due to a mental , b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , nurse, or an individual supervised by one of these professionals.	AL241		

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AL241	Continued From page 27 a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for [redacted] ( ) form, CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hopsital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the	AL241		

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frequency and duration of such services,
c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities,
d. Includes the [illegible] of the facility to facilitate and assist the resident in attending [illegible] and arranging transportation to [illegible] for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager,
e. Includes a description of other services to be provided or arranged by the facility,
f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms [illegible] to the resident that indicate the immediate need for professional mental health services,
g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan,
h. Is updated at least annually or if there is a significant change in the resident's behavioral health,
i. [illegible] include the [illegible] Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and,
j. Must be available for inspection to those who have legal authority to review the document.
4. [illegible] Agreement. The mental health

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AL241	Continued From page 29 care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide a copy of each residents community's living support plan and the	AL241		

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AL241	Continued From page 30 agreement with the mental health care service provider or provide written evidence that a request was made for the community living support plan, for 1 of 3 sampled resident records reviewed (Resident # 2). The findings included: Resident #2's Health Assessment completed on documents diagnoses of difficulty walking, ( ), and . She has an unsteady gait, and uses wheelchair for assistance. She has an order for continuous and is a smoker. She is identified as a Limited Mental Health (LMH) resident. The form further states the resident requires daily oversight in daily rounds for the resident's whereabouts, reminders for important tasks and wellbeing. She requires supervision with bathing and transferring. The Physician documented her Status as ". On at 08:30 AM, a request was made for the residents LMH Community Living Support Plan and Agreement. The Director of Operations provided the document as requested. However, the plan was not dated. It could not be determined if the facility had developed and signed the Community Support Plan on an annual basis with appropriate parties, as required. The resident was provided services from the , Psychiatrist, and Crisis Management. The non-clinical services were to be provided by the local mental health agency. On at 12:00 PM, an interview was conducted with the Administrator. He acknowledged the findings.	AL241		

Agency for Health Care Administration

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