

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968725</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/19/2022</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**GREEN LIFE ASSISTED LIVING**

**840 SW 8TH STREET  
POMPAHO BEACH, FL 33060**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>An unannounced Change Of Ownership (CHOW) with Limited Mental Health (LMH) and a Generator Monitoring survey were conducted on ..... at Green Life Assisted Living. The facility had a deficiency identified related to Limited Mental Health at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | A 000               |                                                                                                                          |                          |
| AL243                    | 429.075(1) FS; 59A-36.011(9) FAC LMH - Training<br><br>429.075<br>(1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families.<br><br>59A-36.011<br>(9) LIMITED MENTAL HEALTH TRAINING.<br>(a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training:<br>1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. | AL243               |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968725</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/19/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREEN LIFE ASSISTED LIVING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>840 SW 8TH STREET<br/>POMPAHO BEACH, FL 33060</b> |                                                                                                                          |  |                                                        |
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| AL243                                                                 | <p>Continued From page 1</p> <p>a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility.</p> <p>b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule.</p> <p>2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics:</p> <p>a. Mental health diagnoses; and,</p> <p>b. Mental health treatment such as:</p> <p>(i) Mental health needs, services, behaviors and appropriate interventions;</p> <p>(ii) Resident progress in achieving treatment goals;</p> <p>(iii) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and,</p> <p>( ) Crisis services and the procedures.</p> <p>3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule.</p> <p>4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement.</p> <p>(b) Administrators, managers and staff do not</p> | AL243                                                                                         |                                                                                                                          |  |                                                        |

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| AL243                                                                 | <p>Continued From page 2</p> <p>have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure 2 out of 3 sampled staff (Staff B and Staff C) had completed Limited Mental Health (LMH) training as required for new employees and biennially.</p> <p>The findings included:</p> <p>On _____, the personnel files for Staff B and Staff C were reviewed for training in LMH. The following certificates showing completion of training were not present in the files:</p> <p>a. Home Health Aide Staff B, hired on _____ to work the 3:00 PM to 11:00 PM shift, had no training on file. A minimum of 6 hours of training is required to be completed within 6 months of hire.</p> <p>b. Certified Nursing Assistant Staff C, hired on _____ to work the 11:00 PM to 7:00 AM shift, had no certificate showing completion of 3 hours of training on file dated within the last 2 years. The last training certificate was dated _____.</p> <p>The Administrator was notified of these findings on _____ at 1:00 PM. The facility provided no additional information for review at this time.</p> <p>Class III</p> | AL243                                                                          |                                                                                                                          |  |                                                        |

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