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
	AL11968958	A. BUILDING: _____ B. WING _____	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN STREET ALF, CORP	12262 SW 250 TERR MAIMI, FL 33032

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective [illegible], or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before [illegible], initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective [illegible], initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an updated staff roster. Staff G Caregiver was not listed. Findings: Interviewed on at 6:45 AM Staff B (caregiver) stated that she was not working when Resident #1left the house on . Staff B stated further that Staff G (Caregiver) was working. Interviewed on at 12:48 PM Staff G (Caregiver) stated that she was not working there now and that she worked there for two months. Staff G stated Resident #1 would come in and go out. Staff G stated, "Whenever he left, he said that he would get some juice. But he never left and did not come . I was not working that day. I do not remember the dates. I don't know who called the police. I do not remember the last	CZ814		

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CZ814	Continued From page 2 day working. He would go and come. I would not know where he was going." When asked if juice was in the facility, Staff G stated, "He would say that he was getting juice just as an excuse." Interviewed on at 2:00 PM Staff B stated that Staff G worked for weeks. A review of the background screening clearinghouse database found no documentation of Staff G on the roster. Interviewed on at 2:45 PM the Administrator acknowledged that Staff G was not on the roster. Unclassified	CZ814		

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A 000	Initial Comments A biennial survey was conducted at Green Street ALF, Corp. from [redacted] through [redacted]. The provider had deficiences at the time of the survey.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide adequate supervision and ensure the safety and well-being of 1 out of 4 sampled residents (Resident 1). Resident 1 left the facility without staff knowing his whereabouts multiple times. The last time, he collapsed and was found by strangers, then hospitalized with life-threatening conditions. The facility also failed to maintain documentation and notify a health care provider of significant changes of condition that required medical attention for 1 out of 4 sampled residents (Resident 1). Findings included:	A 025		

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A 025	Continued From page 2 Interviewed on . . . . . at 11:53 AM Resident 1's sister stated that on . . in the evening Staff D called her but she did not talk to her until the next day, on when she told her that Resident 1 had left the facility at around noon on and had not returned. The Resident's sister further stated that she told Staff D to call the police, and that the Resident's whereabouts were unknown for more than 2 weeks, until an insurance social worker notified her that the Resident was in the hospital. Resident 1's sister also stated that Resident 1 had eloped from the facility several times before. She stated, "Many times, at least 5 or 6 times this year. Sometimes he was gone for days, and the police would find him. One time, he was found in a private home. This happened about three months ago. Another time an ambulance took him to the hospital; he had all kinds of medical conditions. The hospital doctor called me to tell me that the facility should take better care to prevent more elopements because he was in danger. The facility told me that there was nothing that they could do because he was free to go out." Resident 1's sister stated that Resident 1 had been diagnosed with , and , for most of his adult life and had spent time in a mental institution. A review of the police report dated showed: "Upon arrival, I made contact with reporting person [Staff B Caregiver] who advised that missing [Resident #1] has not returned home since . Reporting person [Staff B Caregiver] stated that he was last seen by the nurse other [Staff F Caregiver] who works at the ALF Home on Saturday around 12:30 hours and has not returned home. Missing [Resident #1] has left home before on his own but normally returns home the same day. Missing [Resident #1] is	A 025		

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A 025	Continued From page 3 diagnosed with [illegible] and [illegible]. Reporting person [Staff C Caregiver] is worried as he has not taken his medication since the last time he was seen. Missing [Resident #1] does not have a phone." A review of the emergency medical service's run record dated [illegible] showed that Resident 1 was found over 4 miles away from the facility where he resided. Further review of the emergency service's run record narrative showed: "Upon arrival found [Resident 1] lying [illegible] down for an unknown amount of time in the heat, on the ground with one shoe and no shirt, unresponsive but breathing. [Resident 1] had pinpoint pupils and was not responding to painful stimulation. [Resident 1] had no identification on him, and we were unable to obtain any medical history. [Resident 1] was carried on a stretcher and loaded in the rescue. [Resident 1] was treated in route to the hospital but remained [illegible] the entire time even throughout the treatments. After Narcan was given the pupils were no longer pinpoint but was still unresponsive." A review of Resident 1's hospital discharge record dated [illegible] showed that Resident 1 presented to the hospital emergency department via [illegible] (Emergency medical service) on [illegible] after he was found unresponsive and was diagnosed with heat [illegible] and [illegible]. According to the CDC (Center for [illegible] Control) "Heat [illegible] is the most serious heat-related illness. It occurs when the body 's temperature rises rapidly, the sweating mechanism fails, and the body is unable to cool	A 025		

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A 025	Continued From page 4 down. Heat [illegible] can cause permanent [illegible], or [illegible] if the person does not receive emergency treatment." According to the National Library of Medicine, "[illegible] occurs when the body does not have as much water and fluids as it needs. Severe [illegible] is a life-threatening emergency" According to The National [illegible] Foundation "[illegible] means your [illegible] are no longer able to work well enough to keep you alive. With [illegible] 85-90% of [illegible] function is gone. People with [illegible] will need [illegible] or a [illegible] to survive." According to the Cleveland Clinic," [illegible] is an [illegible] of the [illegible] caused by inhaling saliva, food, liquid, [illegible] and even small objects. If left untreated, complications can be serious, even fatal" According to the Mayo Clinic, " [illegible] ([illegible]) is a type of irregular heartbeat, also called an [illegible]. It's a very fast or erratic heartbeat that affects the [illegible]'s upper chambers." A review of Resident 1's health assessment dated [illegible] showed diagnoses of [illegible], [illegible] and [illegible]. The [illegible] status showed a history of [illegible]. Nursing requirements showed [illegible]. The special precautions section was left blank, and the resident was not identified as an elopement risk.	A 025		

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A 025	Continued From page 5 The activities of daily living showed the Resident was independent in ambulation, bathing, [illegible], eating, self-care, toileting and transferring. The resident needed assistance with self-administration of medication. A review of Resident 1's record showed no documentation that the health care providers had been notified about Resident 1's elopements and hospitalizations. A review of Resident 1's community living support plan found no documentation of case management or a plan for resident care. Interviewed on at 3:51 PM Resident 1's health insurance plan Case Manager Supervisor stated that on Staff D had notified the assigned case manager that Resident 1 had walked out of the facility on and the facility did not know where he was. The Case Manager Supervisor stated that the case manager located Resident 1 at the hospital and notified the facility. Interviewed on at 11:45 AM Resident 1's health insurance Case Manager Supervisor stated that on Staff D notified the Resident's case manager that Resident 1 left for a walk, took his clothes and did not come , and the facility had contacted the police on . The Case Manager Supervisor stated that on Staff D reported that Resident 1 was found on at a gas station and that he did not remember what had happened to him. The Case Manager Supervisor also reported that Resident 1 had been admitted to the hospital on and on . Interviewed on at 2:00 PM Staff B, a	A 025		

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A 025	Continued From page 6 caretaker at the facility stated, "I was there on one occasion when he left." Staff B stated, "[Resident 1] jumped over the fence, threw his clothes over and left everything." When she was asked what measures the facility took after that event, Staff B stated that they talked to Resident 1 and he would eventually come . . to his senses, but he was allowed to leave the facility, and she had to let him go out. Staff B further stated that she was not working on the last time Resident 1 eloped. She also stated that Staff E, who was working on that day, told her that Resident 1 said that he was walking to the corner, and never came . She stated, "They found him in the street, it happened a month ago. He was in the hospital, and he is in rehabilitation now." Interviewed on . . . . . at 10:12 AM the Administrator stated, "He used to go out and walk because he could make his own decisions. He told them that he was going to walk around the neighborhood. I did not call the police. Maybe the owner called. He was not missing. He had a . . . . . He never eloped before." When the Administrator was asked why the police were called on . . . . . , 48 hours after it was determined that the Resident was missing, she stated, "I don't have that information." Interviewed on . . . . . at 3:07 PM the Owner stated that he notified the police that Resident 1 was missing on Monday, ... after the Resident's sister told them to call. When he was asked if he had notified the psychiatrist when Resident 1 had eloped before and returned wearing only his underwear the Owner stated, "No." Interviewed on at 1:30 PM the	A 025		

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A 025	Continued From page 7 Advanced Practice Registered Nurse (ARNP) who signed Resident 1's community living support plan stated that she was not aware of the Resident's history of elopements and hospitalizations, and she did not provide mental health services to him. She stated, "He has a psychiatrist at a clinic. I did not provide mental health services to him, I only saw him as a courtesy, when I visited other residents at the facility, I only did some paperwork for him to help, but I was not informed about his elopements". Interviewed on . . . . . at 4:30 PM Resident 1's psychiatrist stated that the facility never notified her about the Resident's elopements, she had never participated in a community living support plan for the Resident and she assumed that a mental health provider at the facility would have done it for him. A review of the facility's Elopement Policy and Procedure showed, "The police will be notified as soon as it has been determined that the resident is not in the facility and is missing by the administrator. The appropriate notification and documentation required by law and be completed. The administrator fills out adverse incident report 1-day and fax to the [agency] within 24 hours. At [facility], the first step in preventing elopement is to identify those residents with identifiable potential to . . . . or elope. This initial assessment at [facility] will be performed during the admission process to ascertain the resident's history of . . . . ,/elopement, as well as alteration in mental status that could potentially contribute to . . . . ,/elopement behavior. Experience has demonstrated that any type of new environment may trigger a desire to leave a facility. All new residents with any , or	A 025		

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A 025	Continued From page 8 depressed affect will be considered at increased risk during this time frame. At [Facility], after all initial assessment, routine assessment will be completed to determine changes in mental status, behavior, and the effectiveness of the chosen interventions. [Facility] still will monitor the resident's behavior because these types of changes may occur subtly and gradually overtime" Interviewed on . . . . . at 2:37 PM when the Administrator was asked what had the facility do to prevent Resident 1's elopement she stated that the Resident had not eloped because he was aware of where he was, that only once he went to the wrong house by mistake, that could happen to anyone and the facility could not prevent him from going outside. When she was asked why the mental health providers were not alerted about Resident 1's elopement incidents she stated that because the Resident was alert and oriented the facility would not infringe on his right to come and go at will. Class I	A 025		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar	A 032		

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A 032	Continued From page 9 days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including	A 032		

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A 032	Continued From page 10 specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow the elopement policies and procedures for one out of four (Resident #1) sampled residents. The facility did not call the police until two days after Resident #1 went missing. Resident #1 was found by passersby, 4.2 miles away from the facility. The resident was found with no identification on his person and was labeled as a 'Foxtrot/unknown male.' The resident left the facility at least three times without staff knowing his whereabouts before the last elopement. The facility did not report any incidents, did not contact the resident's medical provider, did not update the health assessment and did not put any elopement precautions in place for the resident's safety. Findings: A review of Resident #1's health assessment with a completion date of showed a diagnosis of . The status showed the history of . The nursing requirements showed . The special precautions were left blank. The activities of daily living showed independence in ambulation,	A 032		

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A 032	Continued From page 11 bathing, [redacted], eating, self-care, toileting and transferring. The resident needed assistance with self-administration of medication. The resident was not listed as an elopement risk. Review of Resident #1 community living support plan dated [redacted] revealed the resident was at risk for elopement. Interviewed on [redacted] at 2:42 PM Resident #1 family stated, "He eloped several times. He was found by the police and sometimes he was gone for days. One time when he eloped, he was found in a private home. My brother was able to give the people my number and they called me." Interviewed on [redacted] at 2:00 PM Staff B (caregiver) stated, "I was there on one occasion when he [Resident #1] left." When asked about the time when the resident returned to the facility in his underwear, Staff B stated that Resident #1 said that he jumped over a fence and threw his clothes over and left everything. When asked what the facility did after this event, Staff B stated that Resident #1 would recuperate and would come to his senses. Interviewed on [redacted] at 10:12 AM when asked who called the police when Resident #1 went missing from the facility, the Administrator stated, "I did not call the police. Maybe the owner called. He was not missing. He had a [redacted]. He never eloped before." A review of a police report dated [redacted] showed that the facility representative told the officers that Resident #1 was missing on [redacted]. According to the police report, the staff also told the officer that the resident had gone missing before.	A 032		

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A 032	Continued From page 12 Interviewed on at 3:07 PM, concerning Resident #1 missing from the facility on /04/24, the Owner stated that he called the police on . . . . . The Owner stated that the sister knew he did not call the police until 48 hours. The Owner stated that the sister instructed him to call the police. Interviewed on at 11:45 AM, Resident 1's Case Manager Supervisor stated that on Staff D (Caregiver) notified the Resident's case manager that Resident 1 left for a walk, took his clothes, and did not come , and the facility had contacted the police on . The Case Manager Supervisor stated that on . . . . . Staff D reported that Resident 1 was found on at a gas station and that he did not remember what had happened to him. The Case Manager Supervisor also reported that Resident 1 had been admitted to the hospital on and on . A review of the ambulance record dated . . . . . documented that the resident was found down on a bicycle trail by bystanders. The report stated, "Upon arrival found patient lying down for an unknown amount of time in the heat on the ground with one shoe on and no shirt, unresponsive but breathing. The patient had no identification on him, and we were unable to obtain any medical history. Interviewed on at 2:45 PM, when asked if Resident #1 eloped from the facility before, the Administrator stated, "No." When informed that according to the police report the resident was missing before, the Administrator did not comment. When asked if Resident #1 was ever reassessed for elopement, per the	A 032		

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A 032	Continued From page 13 facility policy, the Administrator stated that he was never reassessed for elopement. The Administrator further stated, "When he [Resident #1] went into the wrong house, it was a mistake and he was . . . . . , but it was not an elopement." Review of the facility , and elopement policy revealed, "With every resident admitted to the facility, we assume a , level of risk-especially if the resident has a tendency to elope and/or . . Further review of the facility elopement policy showed, Elopement" refers to an unauthorized absence of a resident from the facility. The risk of . . . . . and elopement increases when residents are mobile and . . . . . The elopement policy showed the family members will be notified by management (Administrator) within one-half hour of the elopement. The police will be notified as soon as it has been determined that the resident is not in the facility and is missing by the Administrator. A photograph of the resident (applicable) will be furnished to the police by the Administrator. The Administrator will inform the health care providers. The appropriate notification and documentation required by law and rules will be completed. Administrator will fill out Adverse Incident Repot. It is the policy of the facility to establish a method of assessing residents for risk of . . . . . and eloping at the time of the admission. Develop and implement preventive measures to make sure to stop . . . . . and elopement whenever possible. As the facility, after the initial assessment, routine reassessment will be completed to determine changes in mental status, behavior, and the effectiveness of the chosen interventions. Each resident may exhibit individual behavior patterns for /eloping, calling for a variety of	A 032		

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A 032	Continued From page 14 interventions tailoress to specific patterns. Review of the facility records showed no documentation the facility reported any elopement incidents from Resident #1, no documentation the resident medical provider was contacted for behavior changes, previous and current elopements, no updated the health assessment indicated the resident had been reassessed for elopement, and no documentation any elopement precautions was put in place to avoid repeated elopement occurrences and the resident's safety. Class II	A 032		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an . . syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The	A 052		

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A 052	Continued From page 15 resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . . . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a . . . , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, . . . , converting, or ⌣ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a ⌣ of the body. (d) Administration of , . . . preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or ⌣ preparations.	A 052		

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A 052	Continued From page 16 (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and	A 052		

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A 052	Continued From page 17 make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.	A 052		

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A 052	Continued From page 18 (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff B (Caregiver) orally advise one out of six sampled residents the name and dosage of the medications. Findings: Observation on at 12:01 PM Staff B popped the medication into her while wearing latex gloves, handed it in a small receptacle to Resident #5 without naming the medication and dosage. A review of Resident #5's records showed no medication waiver to opt of being orally advised of the medication name and dosage. Interviewed on at 2:45 PM the Administrator acknowledged that the employee did not name the medication and the dosage. Class III	A 052		
A 080 SS=F	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist	A 080		

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A 080	Continued From page 19 facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting , neglect, and . (c) Special needs of elderly persons, persons with mental illness, and persons with , and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with 's and related . 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test.	A 080		

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A 080	Continued From page 20 (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , , , , and managers who attended the core training program prior to , , , , , shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by:	A 080		

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A 080	Continued From page 21 Based on record review and interview, the facility failed to ensure that the Administrator satisfy the continuing education training requirements of 12 hours every two years, and now must retake the CORE training and CORE competency test. The Administrator is required to retake the core training and examination. Findings: A review of the Administrator's personnel records found no documentation of current 12 hours of continuing education training every two years. Interviewed on at 2:45 PM the Administrator stated that the Owner had her training. Class III	A 080		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of	A 084		

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A 084	Continued From page 22 medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, . , . . dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;	A 084		

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A 084	Continued From page 23 e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of , bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have	A 084		

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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 084	Continued From page 24 successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff B (Caregiver) obtained the initial four hours of assistance with self-administration of medication training by an unlicensed staff. Findings: Observation on at 12:01 PM Staff B provided self-administration of medication to Resident #5. A review of Staff B's personnel records found no initial four hours of assistance with self-administration of medication training by an unlicensed staff. Interviewed on at 2:45 PM the Administrator acknowledged that Staff B did not	A 084		

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	AL11968958	A. BUILDING: _____ B. WING _____	07/09/2024

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A 084	Continued From page 25 have the initial 4 hours of assistance with self-administration of medications training. Class III	A 084		
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 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 to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, 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	A 152		

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A 152	Continued From page 26 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 . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe living environment, free of hazards for four out of four sampled residents. Findings: Observation on at 6:33 AM found the kitchen cabinet door appeared to have water damage. Photographic evidence obtained. Observation on at 6:40 AM found what appeared to be black spots on the awning at the rear of the house. Photographic evidence obtained. Observation on at 6:41 AM found a light bulb was missing from the patio light. Photographic evidence obtained. Interviewed on at 2:45 PM the Administrator acknowledged the issues. Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained	A 160		

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A 160	Continued From page 27 in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C.	A 160		

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A 160	Continued From page 28 (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills.	A 160		

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A 160	Continued From page 29 (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update the admissions and discharge log for one (#6) out of six sampled residents the identification of or home address to which the resident was discharged to. Findings: A review of the admissions and discharge log showed Resident #6 was admitted on and was discharged on to "Family House" but without a documented address. Interviewed on at 2:45 PM the Administrator acknowledged that there was no address to where Resident #6 was discharged to. Class III	A 160		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records	A 162		

Agency for Health Care Administration

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A 162	Continued From page 30 must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their	A 162		

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A 162	Continued From page 31 representatives, or their physicians request in writing that [redacted] not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an [redacted] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [redacted] ([redacted]), CF-ES 1006, [redacted], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form 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 Department of Children and Families.	A 162		

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A 162	Continued From page 32 (m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure an accurate and complete health assessments for two (#1, #4) out of six sampled residents. Findings:	A 162		

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A 162	Continued From page 33 1) Observation on . . . . . at 6:33 AM found Resident #4 walking independently throughout the house. A review of Resident #4's health assessment with a completion date of for activities of daily living showed Resident #4 needed total care for ambulation, bathing, , eating, self-care, toileting and transferring. 2) A review of Resident #1's health assessment with a completion date of showed section one for "Special Precautions" was left blank. Interviewed on . . . . . at 2:45 PM the Administrator acknowledged that the health assessments were inaccurate and left blank. Class III	A 162		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is	A 165		

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A 165	Continued From page 34 required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.	A 165		

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A 165	Continued From page 35 (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 165		

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A 165	Continued From page 36 failed to file an adverse incident report for one (#1) out of six sampled residents who eloped and was found on the street unresponsive. Findings: A review of the Adverse Incident Reporting Systems (AIRS) database found no report of Resident #1's elopement on . . . . . . A review of the police report filed by the facility on showed Resident #1 eloped on . . . . . . A review of Resident #1's hospital records dated documented, "[Resident #1] is a 64 y/o male with PMH (primary medical history) of , that presented to the hospital via emergency management services ( ) after he was found unresponsive. Per report patient was given Narcan with no improvement in mental status. Initial vitals signs significant for , ... Patient was initially intubated for airway protection. Patient was admitted to the . . (. . . . .) under our internal medicine service for further evaluation and treatment. Per report patient apparently had . . during activity. . Patient extubated on . . . . ." A review of the facility's elopement policy showed: "The police will be notified as soon as it has been determined that the resident is not in the facility and is missing by the administrator. The appropriate notification and documentation required by law and be completed. Administrator fill out adverse incident report 1-day and fax to the [agency] within 24 hours. Interviewed on at 3:07 PM the Owner	A 165		

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A 165	Continued From page 37 stated that he called the police on Monday, . . , . . , two days after the resident went missing. Interviewed on at 2:45 PM the Administrator stated that their consultant told them not to file an adverse incident report because [Resident #1] did not elope. The Administrator stated further that she regretted not filing a report. Interviewed on . . . . . at 2:42 PM the sister of Resident #1 stated that her brother eloped several times. Class III	A 165		
A 182 SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that all staff were capable of implementing the emergency plan. Findings: Observation on . . . . . at 6:33 AM Staff B	A 182		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN STREET ALF, CORP	12262 SW 250 TERR MAIMI, FL 33032

(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 182	Continued From page 38 was working alone with four residents. Interviewed on at 7:36 AM when asked what was a monoxide detector, Staff B stated that she was responsible for the generator and that the Owner knows all of that and that he comes every day. A review of Staff B's personnel records showed a hire date of and Emergency Environmental Control Plan training on . Interviewed on at 2:45 PM the Administrator acknowledged that Staff B did not know what a monoxide detector was. Class III	A 182		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the	A 200		

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A 200	Continued From page 39 event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit	A 200		

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A 200	Continued From page 40 for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F. S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include	A 200		

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A 200	Continued From page 41 information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . . monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that	A 200		

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A 200	Continued From page 42 undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . . . , ..., have implemented the plan	A 200		

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A 200	Continued From page 43 required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the	A 200		

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A 200	Continued From page 44	A 200		

written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request.
(c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law.
(6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines.
(7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN.
(a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule.
(b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan.
(8) NOTIFICATION.
(a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has

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A 200	Continued From page 45 been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of an approved emergency power plan (EPP). Findings: A ecord review of the emergency power plan showed no documentation of approval from the local emergency management agency. Interviewed on . . . . . at 2:45 PM the Administrator acknowledged that an approved emergency power plan was not available.	A 200		

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A 200	Continued From page 46 Class III	A 200		
AL242 SS=H	429.075(2) FS; 59A-36.020(3) FAC LMH - Responsibilities of Facility 429.075 (2) A facility that is licensed to provide services to mental health residents must provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents. 59A-36.020 (3) RESPONSIBILITIES OF FACILITY. In addition to the staffing and care standards of this rule chapter to provide for the welfare of residents in an assisted living facility, a facility holding a limited mental health license must: (a) Meet the facility's to assist the resident in carrying out the activities identified in the Community Living Support Plan; (b) Provide an opportunity for private -to- contact between the mental health resident and the resident's mental health case manager or other treatment personnel of the resident's mental health care provider; (c) Observe resident behavior and functioning in the facility, and record and communicate observations to the resident's mental health case manager or mental health care provider regarding any significant behavioral or situational changes that may signify the need for a change in the resident's professional mental health services, supports, and services described in the community living support plan, or that the resident is no longer appropriate for residency in the facility; (d) If the facility initiates an involuntary mental health examination pursuant to section 394.463, F.S., the facility must document the	AL242		

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AL242	Continued From page 47 circumstances leading to the initiation of the examination; (e) Ensure that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C.; and, (f) Maintain facility, staff, and resident records in accordance with the requirements of this rule chapter. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide appropriate supervision to ensure the health, safety and welfare of 1 out of 4 sampled mental health residents (Resident 1) The facility also failed to observe, record and communicate observations to the mental health care provider of significant behavior that may require the need for a change in the mental health services or that the Resident was no longer appropriate for residency in the facility for 1 out of 4 sampled mental health residents (Resident 1). Findings included: A review of the facility records showed that Resident 1 was receiving limited mental health services. Interviewed on at 1:30 PM the Advanced Practice Registered Nurse (ARNP) who signed Resident 1's community living support plan stated that she was not aware of the Resident's history of elopements and hospitalizations, and she did not provide mental health services to the Resident. She stated, "He has a psychiatrist at a clinic. I did not provide mental health services to him, I only saw him as a courtesy, when I visited other residents at the facility, I only did some paperwork for him to help,	AL242		

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AL242	Continued From page 48 but I was not informed about his elopements". Interviewed on . . . . . at 4:30 PM Resident 1's psychiatrist stated that the facility never notified her about the Resident's elopements, she had never participated in a community living support plan for the Resident and assumed that the facility would have arranged that for him. Interviewed on at 2:37 PM when the Administrator was asked why the mental health providers were not alerted about Resident 1's elopement incidents she stated that because the Resident was alert and oriented the facility could not infringe on his right to come and go at will. Interviewed on . . . . . at 3:51 PM Resident 1's health insurance plan Case Manager Supervisor stated that on . . . . . Staff D from the facility notified the assigned case worker that Resident 1 had walked out of the facility on and the facility did not know where he was. The Case Manager Supervisor stated that the case worker located Resident 1 at the hospital and notified the facility. Interviewed on . . . . . at 11:45 AM Resident 1's health insurance Case Manager Supervisor stated that on . . . . . Staff D notified the Resident's case worker that Resident 1 had left for a walk, took his clothes and did not come , and the facility had contacted the police on . . . . . . The Case Manager Supervisor stated that on Staff D reported that Resident 1 was found on . . . . . at a gas station and that he did not remember what had happened to him. The Case Manager Supervisor also reported that Resident 1 had been admitted to the hospital on . . . . . and on	AL242		

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AL242	Continued From page 49 Interviewed on [redacted] at 9:50 AM Resident 4 stated that Resident 1 had eloped before and that on one occasion he came [redacted] wearing only his underwear. Interviewed on [redacted] at 3:07 PM when he was asked if he had notified the psychiatrist when Resident 1 eloped and returned wearing only his underwear the Owner stated, "No." Interviewed on [redacted] at 11:53 AM Resident 1's sister stated that on [redacted] Staff D notified her that Resident 1 had left the facility at around noon the previous day and had not returned. The Resident's sister also stated that the Resident's whereabouts were unknown for more than 2 weeks until an insurance case worker notified her that the Resident was in the hospital after he was found unresponsive by rescue. She stated," The facility told me that there was nothing that they could do because he was free to go out." Resident 1's sister further stated that Resident 1 had been diagnosed with [redacted] and [redacted] for most of his adult life and had spent time in a mental institution before he was admitted to the facility. A review of Resident 1's record showed no documentation that the mental health care providers had been notified about Resident 1's behavior and elopement incidents. A review of Resident 1's community living support plan found no documentation of case management or a plan for resident care. A review of Resident 1's health assessment dated [redacted] showed diagnoses of [redacted] and [redacted]. The [redacted] status showed a history of [redacted]. Nursing	AL242		

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AL242	Continued From page 50 requirements showed . . . . . The special precautions section was left blank, and the resident was not identified as an elopement risk. The activities of daily living showed the Resident was independent in ambulation, bathing, . . . eating, self-care, toileting and transferring. The Resident needed assistance with self-administration of medication. A review of the emergency medical service's run record dated . . . . . showed that Resident 1 was found over 4 miles away from the facility where he resided. Further review of the emergency service's run record narrative showed: "Upon arrival found [Resident 1] lying down for an unknown amount of time in the heat, on the ground with one shoe and no shirt, unresponsive but breathing. [Resident 1] had pinpoint pupils and was not responding to painful stimulation. [Resident1] had no identification on him, and we were unable to obtain any medical history. [Resident 1] was carried on a stretcher and loaded in the rescue. [Resident 1] was treated in route to the hospital but remained ( ) the entire time even throughout the treatments. After Narcan was given the pupils were no longer pinpoint but was still unresponsive." A review of Resident 1's hospital discharge record dated . . . . . showed that Resident 1 presented to the hospital emergency department via . . . (Emergency medical service) on after he was found unresponsive and was diagnosed with heat . . . , , , , and According to the CDC (Center for . . . . . Control) "Heat . . . is the most serious	AL242		

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AL242	Continued From page 51 heat-related illness. It occurs when the body 's temperature rises rapidly, the sweating mechanism fails, and the body is unable to cool down. Heat can cause permanent , or if the person does not receive emergency treatment." According to the National Library of Medicine, " occurs when the body does not have as much water and fluids as it needs. Severe is a life-threatening emergency" According to The National Foundation " means your are no longer able to work well enough to keep you alive. With 85-90% of function is gone. People with will need or a to survive." According to the Cleveland Clinic," is an of the caused by inhaling saliva, food, liquid, and even small objects. If left untreated, complications can be serious, even fatal" According to the Mayo Clinic, " ( ) is a type of irregular heartbeat, also called an . It's a very fast or erratic heartbeat that affects the hearts' upper chambers." 2. A review of Resident 2's record showed no documentation that the mental health care providers had been notified about Resident 2's progress. A review of Resident 2's community living support plan found no documentation of case	AL242		

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
	AL11968958	A. BUILDING: _____ B. WING _____	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN STREET ALF, CORP	12262 SW 250 TERR MAIMI, FL 33032

(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
AL242	Continued From page 52 management or a plan for resident care. Class II	AL242		