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
	AL11968333	A. BUILDING: _____ B. WING _____	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE JUPITER	1031 COMMUNITY DRIVE JUPITER, FL 33458

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Licensure Complaint survey, #2025011949 was conducted on to at Addington Place Jupiter. The facility had deficiencies identified at the time of the survey.	A 000		
A 152	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	A 152		

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A 152	Continued From page 1 commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that all architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. The findings included: The facility is a two story facility that houses Independent living(IL), Memory Care and Assisted Living Facility (ALF) residents. The facility's ALF (including Memory Care unit) census at the time of survey was 71. The facility had a central air conditioning(a/c unit) unit that was responsible for providing cooling air (temperatures below 81) to the entire building. On around 10 AM, the Agency received notice that the facility's central air conditioning unit had a mechanical failure resulting in the entire system and no longer operating, no cooling source. This mechanical failure resulted in a complete loss of central air conditioning unit and temperatures rising above 81 degrees throughout the 2 story facility. A review of the facility's grievance log revealed multiple residents complaining about the facility's air conditioning system and it being extremely hot in the building since . Multiple	A 152		

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A 152	Continued From page 2 confidential resident and family interviews conducted on between 1:45 PM and 9:30 PM revealed the facility's air conditioning system has not been working properly for months and some days it gets extremely hot. It was revealed that the Administrator and management staff were aware of the problem. During an interview with the Administrator on at 1:45 PM, he confirmed that the facility's air conditioning unit had a major in which the first floor flooded due to pipes connected to the unit bursting resulting in the entire unit shuting down and no longer operating. The Administrator confirmed that the facility had problems with the unit prior and that they had attempted to resolve the problem. However, it was determined that the facility required addtional repair work to prevent furture cooling problems to the a/c unit. He stated, the facility has with a a/c repair company to temporary resolve the problem until the major repairs could be completed within the next few weeks and/or months. He stated, the Corporate office is working on this problem. On , the facility was unable to establish the facility air conditioning unit in working order to return the facility's temperatures below 81 degrees. The facility due to the temperatures rising above 81 degrees throughout the day (from 2 PM to 9:30 PM), the residents were evacuted under the Agency intervention. The system remained in a non-functioning state and unable to re-establish operating power. Per the Administrator, the contractor/vendor was on site and stated it would take about 24 to 36 hours. Observations of the facility's main central hub for the a/c unit revealed that it was being repaired on the day of the survey. However, it was confirmed	A 152		

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A 152	Continued From page 3 that the repairs were temporary and the unit required a more intense repair work to the entire system. Due to the persistent heat temperatures throughout the building in the afternoon and evening hours on . On at approximately 9:35 PM the PBCFR issued a "Unsafe Condition Order to Vacate the Premises by Order of the Fire Marshal". Review of this order revealed the following: Your are order to vacate the entire facility Memory Care/ALF/IL. No occupancy until further notice. Class III	A 152		
A 182	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 record review and interview, it was determined that the facility failed to effectively and timely implement their Emergency Management Plan when the facility temperature had risen to temperatures above 81 degrees in multiple residents' rooms and common areas within the facility. It was also determined that the facility	A 182		

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A 182	Continued From page 4 failed to have a current CEMP. The findings include: On at around 10:30 A PM, the Agency received notice that the facility's central air conditioning unit experienced a mechanical failure resulting in the complete shut down of the system. On at around 10:50 AM and 11: 20 AM , the Agency received a call from the facility's Administrator regarding the facility's central air conditioning unit not working within the facility and that the facility had no central air conditioning. The Administrator stated, the first floor had a pipe that burst that was connected to the cooling tier system. He stated, that the piped bursted earlier that morning around 8 AM which caused the in the unit and the shut down of the system. He stated, the facility was monitoring the temperatures and had portable spot coolers for all resident's rooms and that the facility had rented an additional 40 spot coolers to place throughout the facility to maintain the temperatures below 81 degrees. He stated, that he had connected all the resident's family members and was ensuring all residents were cool and safe. Upon arrival to the facility around 1:15 PM, on , it was noted that the main entrance of the building was extremely hot. At this time, multiple residents were observed throughout the common area (near the entrance) sweating. The Administrator approached the surveyor, and stated he had a plan and was monitoring everything. The Administrator stated the current census was 71 residents (ALF and memory care unit).	A 182		

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A 182	Continued From page 5 During further interview with the Administrator, documentation regarding the temperature monitoring and purchasing of the additional spot coolers for the residents' rooms were requested. He stated, he had 25 units and more was coming, he was asked when. He stated the Maintenance worker had purchased more and was installing now and would return to purchase more. He stated, the facility was not documenting the tempertures. And that he was unable to identify which rooms received a cooling unit out of the 25 coolers present. Upon entrance to the Memory Care unit approximately 14 residents were observed seated in the front entrance common area. All the residents were observed sweating profusely. The Administrator stated, that staff were monitoring the residents and all residents were in the common area. However, upon tour of the Memory Care wing several residents were observed sitting in their rooms. Temperature readings for these rooms were all above 81 degrees. At this time the Administator was informed and requested to relocate the residents immediately from their rooms to the common area in which the spot coolers were located. He was also reminded that staff must monitor the residents due to their diagnosis and unable to voice any safety concerns (including concerns regarding the temperatures. Further observations of the Memory Care unit revealed several spot coolers positioned blowing air.4 spot coolers were noted position in the common area/dining area windows. However, the vents to circulate the hot air out were not properly secured in the window. At this time, the facility was reminded by the Senior County Planner that	A 182		

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A 182	Continued From page 6 the surrounding area around the spot cooling hoses needed to be enclosed and the vents appropriately positioned. The spot coolers were only observed in the common area, the Administrator confirmed the coolers were only located in the common area of the memory care unit. Although, multiple spot cooler were observed in the common area, multiple temperature readings revealed temperatures above 81 degrees. The Administrator was questioned regarding the available spot coolers for residents rooms as he had previously spoken. He stated that he had enough coolers for every residents room and that some of the residents could double-up and share the room. He stated he Maintenance worker was at the Supply store purchasing more units. At this time, he was asked how many units was he purchasing. He stated, he was not sure. The Administrator was asked to contact the Mainteance worker to obtain a status update on the purchase. However, the Administrator never provided the updated information. The Administrator was reminded that if the temperature were unable to be brought down to 81 degress or lower the residents would have to be evacuated through the execution of their ememergency plan. The Adminstrator assured the surveyor and the Seniror Planner the temperatures could be brought down and that his Mainteance Worker was coming . However, by 2:45 PM, the temperatures in the building had not lowered to acceptable tempertures. Through surveyor intervention, the Administrator was informed that that residents had to be evacuated as the temperature readings in the Memory Care unit were above 81 degrees and the temperatures in the non-secured unit were also	A 182		

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A 182	Continued From page 7 rising. The Administrator was asked to appoint staff to start the evacuation for the unit. It was noted that on from 2 PM until approximately 9:30 PM, the Administrator failed to appoint an liason to assist with the evacation of the non-memory care residents. It was noted that this failure contributed to the delay in the transfer of the residents to alternate living placement, resulting in the residents being exposed to the temperatures for extended periods of time. The facility required the assistance of AHCA intervention, Palm Beach County Planner and Palm Beach County Emergency Management Division to expedite the transfer of the residents due to the unacceptable temperatures within the facility. The Memory Care residents were evacuated at approximately 3 PM on to a sister facility (approximately 35 minutes away by the facility's bus). After all residents in the Memory Care were evacuated, the facility under the intervention of the Agency started to evacuate the ALF residents around 6:30/7PM. The final ALF residents were evacuated from the facility around 9:30 PM on . The residents had to be evacuated to a local hotel, due to the mutual aid agreement not beeing current. The facilities listed in the mutual aid agreement of the CEMP were unable to accomodate the entire population. The facility had 3 mutual aid facilities listed in the plan, in which 2 (1 facility is a sister facility, same ownership) were local and the other facility was located in Georgia. Due to the persistent heat temperatures throughout the building in the afternoon and evening hours on . On at	A 182		

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A 182	Continued From page 8 approximately 9:35 PM the PBCFR issued a "Unsafe Condition Order to Vacate the Premises by Order of the Fire Marshal". Review of this order revealed the following: Your are order to vacate the entire facility Memory Care/ALF/IL. No occupancy until further notice. Review of the facility's Comprehensive Emergency Plan revealed that it was expired, and had been rejected upon initial submission in , and was rejected in . Therefore, on the day of the survey, the facility didn't have a current CEMP , neither had resubmission of the plan been completed. Class III	A 182		