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
	AL11965667	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR OAKS AT GREENACRES ASSISTED LIVING	3400 SOUTH JOG RD GREENACRES, FL 33467

(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 Complaint survey (#2026000028) was conducted from to at Arbor Oaks at Greenacres Assisted Living. The facility had a deficiency identified at the time of survey.	A 000		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

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A 030	Continued From page 1	A 030		

and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where

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A 030	Continued From page 2 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030		

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A 030	Continued From page 3 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

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A 030	Continued From page 4 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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A 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a safe and decent living environment following a fire on that displaced all 25 sampled residents (Residents #). The facility did not notify the Agency and did not activate its Comprehensive Emergency Management Plan (CEMP), resulting in delays in relocating residents from rooms that were water soaked and unsafe for occupancy. The facility then attempted to	A 030		

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A 030	Continued From page 6 return residents to these rooms without clearance from the Fire Marshal or Building Inspector, placing them at additional risk and infringing upon their rights to safety. The findings included: A) On at 9:41 PM, the Agency was notified by the local fire department that a fire occurred at the facility at 8:59 PM, displacing 25 residents and causing structural damage. The facility did not notify the Agency of the incident. During an interview with the Administrator on at 10:50 AM, she confirmed that a fire originated in and displaced 25 residents from the 300 wing and the 100 wing directly below it. She acknowledged she did not notify the Agency and did not activate the facility's CEMP, stating the plan had been submitted but not yet approved. A census was requested at that time. A Record review showed that Residents #1 through 25 were dispersed throughout the facility as follows: a. Residents #2, 3, 6, and 9 were relocated to the Ice Cream Parlor, a common area with no privacy or bathroom. b. Residents # 4, 10, and 19 were relocated to the Oak Room, an activity room with no privacy. c. Residents #15 and 23 were relocated to the Library, a common area with no bathroom. d. Residents # 11 and 18 were relocated to , and Residents number 16, 20, and 21 were relocated to in the 200 wing. e. Residents # 5, 7, 17, 22, and 25 were relocated to the secured memory care unit, despite not being memory care residents.	A 030		

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A 030	Continued From page 7 f. Residents #1, 8, 12, 13, 14, and 25 were staying with family. No documentation was provided showing activation of emergency procedures, coordination with emergency authorities, or implementation of the CEMP's Mutual Aid Agreement. During a tour on at 10:36 AM and again from 11:15 AM to 12:00 PM, the following hazardous conditions were observed: a. The right front entrance door stood propped open with a large planter, allowing the smokey indoor air to drift outside. Both entrance doors were wrapped in bright yellow caution tape (ripped open), signaling restricted access and creating an immediate impression of an unsafe, unstable environment. b. A heavy, lingering odor of smoke mixed with dampness filled the lobby, library, and 100 wing. The air felt thick and humid, carrying the unmistakable scent of recently extinguished fire and wet building materials. c. Ceiling tiles throughout the 100 wing hallway were visibly , sagging downward as if down by trapped water. Dark brown water stains spread across their surfaces, and in , 107, and 108, the tiles appeared and discolored, suggesting ongoing moisture saturation. d. On the second floor, the smell of smoke intensified with each step toward the 300 wing. The air carried a gritty soot odor that clung to clothing and made the hallway feel stale and contaminated. e. Inside , the fire's point of origin, the walls were coated in thick black soot. A large hole gaped open in the ceiling, exposing charred beams. The burnt electrical bed base was partially melted, and the floor was covered in murky standing water mixed with ash and soot.	A 030		

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A 030	Continued From page 8 Two used candles rested on a surface near the bed, surrounded by debris. f. , 306, and 309 contained puddles of water in various stages of drying. Portable fans hummed loudly, blowing damp, musty air around the rooms without eliminating the moisture. g. Resident number 17 lay in bed in , where the air smelled strongly of smoke and moisture. The Administrator acknowledged the room was unsafe but allowed the resident to remain due to hospice status. Despite these conditions, the Administrator stated during an interview on at 12:07 PM that she planned to rent dehumidifiers and fans and have internal maintenance staff complete water remediation. She also stated she intended to return the 19 onsite displaced residents to their rooms once the fire watch was lifted. During a tour on at 10:15 AM, the following were observed: a. The Library, Oak Room, and Ice Cream Parlor were open, unlocked common areas with no restrooms. These spaces were brightly lit, high traffic areas where staff and visitors passed through regularly. The lack of privacy was immediately apparent, with personal belongings and bedding visible from the hallway. b. 9 displaced residents were observed sleeping in these areas. Some lay on beds pushed against walls; others rested in recliners. c. 5 displaced residents were observed sleeping in shared semi private rooms within the secured memory care unit. d. A damp, musty odor permeated both floors, especially in the 300 wing. The air in the 300 wing felt cool and moist, indicating that water may remain trapped in walls, ceilings, and flooring. The Administrator still had not implemented the	A 030		

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A 030	Continued From page 9 CEMP and continued relocating residents to areas that violated their rights to privacy and dignity. B) A record review on showed that 19 displaced residents remained onsite and were placed in memory care, in open common areas, or in other residents' semi private rooms. During the tour from 11:15 AM to 12:00 PM, it was identified that the Library, Oak Room, and Ice Cream Parlor were unlocked, open access common areas without restrooms, no privacy. Despite this, 9 displaced residents (Residents #2, 3, 4, 6, 9, 10, 15, 19, and 23) were relocated to these areas, which did not provide privacy, access to private restrooms, or appropriate supervision. These public spaces were not intended for resident sleeping or extended occupancy and created safety risks including delayed toileting assistance, increased risk, exposure to noise and traffic, and the inability to maintain resident dignity or confidentiality. Additionally, 5 displaced residents (Residents # 5, 7, 17, 22, and 25) were placed in the secured memory care unit. This posed safety concerns for both the displaced residents and the memory care population. The memory care unit was designed for individuals with diagnosed , who required enhanced supervision and a controlled, locked environment. Placing residents who were not assessed or care planned for secured placement restricted their freedom of movement without clinical justification. Their presence also increased the risk of overcrowding and reduced staff attention for residents who legitimately required memory care level	A 030		

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A 030	Continued From page 10 supervision. These relocation decisions created unsafe living conditions and violated residents' rights to be housed in an appropriate environment that ensured privacy, dignity, and protection from harm for a total of 14 displaced residents. During an interview on at 10:30 AM, the Administrator stated the facility was "in the process" of relocating residents to habitable spaces. She was informed that residents could not reside in areas lacking private restrooms or adequate privacy. C) During an interview on at 12:07 PM, the Administrator stated she believed she could return residents to their rooms once water was removed and the fire watch was lifted. She provided a "Remediation Completion Plan" dated documenting her intention to return most displaced residents to their rooms by bedtime on . The plan included water removal and cleaning in through 110 and through 310, with residents scheduled to return the same day. required additional work, and those residents were to remain with family. Fans and dehumidifiers were to be placed throughout the halls and common areas by 4:00 PM using internal maintenance staff. During an interview with the Fire Marshal on at 1:27 PM, he stated that no residents were permitted to return to the 100 or 300 wings and that both he and the Building Inspector were required to clear the areas before occupancy.	A 030		

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A 030	Continued From page 11 During an interview with the Administrator at 1:40 PM, she reiterated her belief that residents could return once water was removed and confirmed she had already begun moving residents' belongings into their rooms. She was informed this was unsafe and contradicted the Fire Marshal's directive. She declined a interview with the Fire Marshal, stating that "corporate could contact them." On at 12:20 PM, the Fire Marshal and Building Inspector assessed the 300 wing and found moisture levels exceeding 300 percent in multiple rooms. At 1:00 PM, the Fire Marshal and Building Inspector stated that both the 100 and 300 wings were uninhabitable and estimated repairs could take 30 days or more. During an interview with the Administrator at 1:35 PM, she confirmed the findings and stated she was still developing a relocation plan. The Agency instructed her to notify families and third-party providers to ensure safe placement of the residents displaced. She stated she was in the process of doing so and that corporate would assist with relocating residents to a sister facility. The facility's attempt to return residents to unsafe, uncleared rooms placed residents at risk of harm and its failure to properly relocate residents to safer environments was the result of continual noncompliance. During an exit interview on at 3:34 PM, the Administrator acknowledged the ongoing relocation issues but did not provide evidence that corrective actions had been implemented prior to Agency intervention. The facility's failure to notify the Agency of the fire, failure to implement its Comprehensive Emergency	A 030		

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A 030	Continued From page 12 Management Plan, placement of residents in unsafe and inappropriate areas, and attempts to return residents to fire affected rooms without clearance collectively demonstrated a systemic breakdown in ensuring resident safety. These actions violated residents' rights to a safe, decent, and hazard free living environment and placed all 25 displaced residents at risk for harm. Class II	A 030		