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
	AL11969228	A. BUILDING: _____ B. WING _____	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVE, LOVE, LAUGH ASSISTED LIVING INC	1766 SW COLUMBIA ST PORT SAINT LUCIE, FL 34987

(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 Cmplaint investigation, #2026004570 was conducted at Live, Love, Laugh Assisted Living Inc on . The facility had deficiencies at the time of the survey.	A 000		
A 004	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C. (4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property"	A 004		

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A 004	Continued From page 1 means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter. (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on interview, observations and record review, it was determined that, the facility failed to maintain six (6) or less residents for which it is licensed to care for. Cross reference A 0032 for additional findings. The findings included: During an interview conducted on at 8:45 AM with Staff B (Caregiver), she stated that the facility census was 8. Observations on at 9:30 AM, confirmed the facility had a census of 8 residents (Resident #1 - Resident	A 004		

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A	Continued From page 2 #8). During an interview conducted on at 9:45 AM, he stated his census was 6 residents with 2 additional family members in which they provide care and services. The Administrator confirmed that the facility was only licensed for 6 residents. The Administrator was informed that he is not allowed to exceed the licensed capacity. Review of the Agency records confirmed the facility was licensed for 6 residents. Further review, confirmed the facility had not applied for or been approved for a capacity increase. Additionally, the facility had not received an approval from the local fire department or health department for additional residents. A review of the facility's admission and discharge log revealed the following: Resident #1 was admitted on Resident #2 was admitted on Resident # 3 was admitted on Resident #4 was admitted on Resident #5 was admitted on Resident #6 was admitted on Resident #7 was admitted on Resident #8 was admitted on Record review also confirmed that the facility had not increased its staffing standards to accomodate the additional residents. Class II	A 004		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007	A 032		

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A 032	Continued From page 3 (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 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	A 032		

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A 032	Continued From page 4 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 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 interview, record review and observations, it was determined that, the facility failed to provide appropriate supervision to a resident that was identified as an elopement risk and exhibited elopement behavior, for 1 out of 1 elopement risk residents (Resident#1). The findings included: A review of the facility's policy and procedures for elopement provided by the Administrator documented the following: i. The priority of this facility is to foster an environment of safety and good quality of life for all residents as much as possible. Should a resident not sign-out in the facility's Sign-Out/Sign In Log (Temporary Absence Log) indicating the	A 032		

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A 032	Continued From page 5 Date, Time and Reason for temporary absence, nor communicated with staff regarding his/her temporary absence, it is therefore understood by the facility that the resident left the facility without following the policy and procedures. Although the resident may travel independently in the community the assisted living staff are responsible for knowing the whereabouts of all residents. When a resident is determined missing or whereabouts is unknown the facility shall make every attempt as quickly as possible to locate the resident. Definition of Elopement: Elopement is when a resident leaves the facility without following the facility's policy and procedures. ii. The following procedures will be followed when it is determined by facility staff that a resident has eloped. 1. Any staff member who is unable to locate a resident after checking the " Sign-In", Sign-Out" log to verify the general whereabouts of the resident, must immediately notify the Administrator or Designee, irrespective of the time of day. 2. If a resident is determined to be missing, all Assisted Living staff are notified and given a description of the resident and details of the last time and place the resident was seen and description of clothing. Photographs of the resident should be made available for identification. 3. All staff members on duty during the period of time the resident was determined missing, shall search all interior and exterior sections of the house/building, and yard. 4. If the resident is found inside or outside of the building (s), the staff discovering the resident	A 032		

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A 032	Continued From page 6 must notify other staff members immediately. 5. After the resident is found the direct care staff in charge, during the period of residents return to facility shall, conduct a thorough observation, evaluation/assessment and follow-up. During a confidential interview conducted on at 8:20 AM, it was revealed that Resident # 1 had eloped on and , and returned by local law enforcement. The interview further revealed that the resident was found several homes away from the facility where he resides. Further interview revealed that Resident #1 was and he was unable to find he way to the facility. Additionally, it was reported that Resident #1 was and unable to find his way to the facility without assistance. During an interview conducted on at 9:10 AM with the Administrator, he stated that Resident #1 eloped on between 2:00 PM and 3:00 PM; however, he was unsure of the exact time. He further stated that he did not have any information to share regarding Resident # 1's second elopement. Additionally, the Administrator reported that Resident #1 was admitted to the facility as an elopement risk. During an interview conducted on at 9:20 AM with Resident #2, she stated that Resident #1 left the facility twice , and staff were searching for him. During an interview conducted on at 10:25 AM with Resident #1, he requested that the surveyor leave him alone and stated that he did not want to talk. During an interview conducted on at	A 032		

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A 032	Continued From page 7 10:31 AM with Staff B (Caregiver on duty at time of the incident)), she stated that Resident #1 was admitted at the facility on at approximately 7:30 PM.Staff B stated that on Resident #1 was in the backyard speaking with another resident. She then realized that Resident #1 was missing. She stated that she saw Resident #1 walking out onto the street but stated that she was afraid to go after him and did not know how he would react. In addition , Staff B stated that the Administrator informed her that he was unaware that Resident #1 was an elopement risk. Staff B stated that Resident# 1 was not appropriate for admission to the facility. Staff B stated that Resident #1 actively sought exits and was attempting to leave the facility. She also stated that during the second elopement incident, she was busy assisting other residents and later realized that Resident #1 was missing again. She stated that Resident #1 was later returned to the facility by neighbors. During an interview conducted on at 10:55 AM with the Administrator, he stated that after the incident he changed the front door lock and he did not provide any elopement training to the staff. During an interview conducted on at 11:18 AM with Resident #2 , he stated that Resident #1 is aggressive and that he is staying away from him. Record review of Resident #1's file revealed the following. Resident was admitted to the facility on . Review of Resident # 1's health assessment (1823) date revealed diagnoses of , , Major	A 032		

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A 032	Continued From page 8	A 032		

, and
( ). The status was noted as requiring constant redirection and memory loss. Resident #1 was also identified as an elopement risk. Further review revealed Resident #1 only required assistance with grooming but was independent with ambulation, bathing, , eating, toileting and transferring.

An additional health assessment (1823) dated on was also reviewed and indicated that Resident #1 requires 24- hour nursing or care.

On , this surveyor made the following observations during the survey conducted from 8:45 AM to 1:30 PM.
1. Resident #1 was observed attempting to locate the exit doors.
2. Resident #1 was pacing in forth in the living room and the dining .
3. Resident #1 refused to eat lunch
4. Resident #1 was observed in the backyard because he managed to exit the facility
5. The surveyor observed that the facility was not secured
6. The facility backyard did not have a fence
7. The Administrator redirected Resident #1 multiple times to return into the home and cease exit seeking tendencies.
8. The surveyor observed Resident #1 was agitated throughout the survey.

Further observations revealed the facility census was 8 residents, including at the time of both of Resident #1's elopements. The facility's overcapacity prevented the facility staff from

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A 032	Continued From page 9 providing appropriate supervision to Resident #1 to prevent elopements. The overcapacity also prevented the facility from safely returning the resident to the facility when he was physical seen living the facility and roaming the neighboorhood. Resident #1's elopement placed him in physical danager as the resident was unable to safely perserve himself while out of the facility as was identified as an elopement risk. Class II	A 032		
A 165	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 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. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her	A 165		

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A 165	Continued From page 10 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. (6) , neglect, or , 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	A 165		

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A 165	Continued From page 11 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 interviews and record review, it was determined that, the facility failed to report an Elopement. The facility failed to submit an Adverse Incident Report within one business day after the occurrence of an adverse incident for 1 of 1 resident sampled (Resident #1). Cross reference A0032 for additional information regarding Resident #1. The findings included: During a confidential interview conducted on at 8: 20 AM, it was revealed that	A 165		

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A 165	Continued From page 12 Resident #1 had eloped on and . During an interview conducted on at 9:10 AM with the Administrator , he confirmed that Resident #1 eloped on , however, he was unable to recall the details of the second elopement. During an interview conducted on at 10:15 AM with the Administrator, he stated that he did not notify the Agency regarding Resident #1's elopements. He further stated that he was unaware that he was required to report the incidents to the Agency. During an interview conducted on at 10:31 AM with Staff B, she confirmed that Resident #1 eloped twice and that he was later retuned at the facility by neighbors. Record review of Resident #1's file revealed the following. Resident was admitted to the facility on . Review of Resident # 1's health assessment (1823) dated revealed diagnoses of , , , Major , , and , ( ). The status was noted as requiring constant redirection and memory loss. Resident #1 was also identified as an elopement risk. Further review revealed Resident #1 only required assistance with grooming but was independent with ambulation, bathing, , eating, toileting and transferring. Resident also noted as an elopement risk . An additional health assessment (1823) dated on was also reviewed and indicated that	A 165		

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A 165	Continued From page 13 Resident #1 requires 24- hour nursing or , , care. Review of the facility's record revealed no documentation of the elopement incidents. No additional documents were provided at that time. Class III	A 165		