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
	AL11943023	A. BUILDING: _____ B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

(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 Wellness Monitoring survey was conducted on [redacted] at Lighthouse Inn North. The facility had a deficiency identified at the time of the survey.	A 000		

AHCA Form 3020-0001

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

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
	AL11943023	A. BUILDING: _____ B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

(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
CZ817 SS=C	408.810( ) FS; 59A-35.100(1) FAC Minimum Licensure Requirement - Inform AHCA 408.810 Minimum licensure requirements.-In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license. (3) Unless otherwise specified in this part, authorizing statutes, or applicable rules, any information required to be reported to the agency must be submitted within 21 calendar days after the report period or effective date of the information, whichever is earlier, including, but not limited to, any change of: (a) Information contained in the most recent application for licensure. (b) Required insurance or bonds. (4) Whenever a licensee discontinues operation of a provider: (a) The licensee must inform the agency not less than 30 days prior to the discontinuance of operation and inform clients of such discontinuance as required by authorizing statutes. Immediately upon discontinuance of operation by a provider, the licensee shall surrender the license to the agency and the license shall be canceled. (b) The licensee shall remain responsible for retaining and appropriately distributing all records within the timeframes prescribed in authorizing statutes and applicable rules. In addition, the licensee or, in the event of or dissolution of a licensee, the estate or agent of the licensee shall: 1. Make arrangements to forward records for each client to one of the following, based upon the client's choice: the client or the client's legal representative, the client's attending physician, or	CZ817		

AHCA Form 3020-0001

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943023	A. BUILDING: _____ B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

(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
CZ817	Continued From page 1	CZ817		

the health care provider where the client currently receives services; or
2. Cause a notice to be published in the newspaper of greatest general circulation in the county in which the provider was located that advises clients of the discontinuance of the provider operation. The notice must inform clients that they may obtain copies of their records and specify the name, address, and telephone number of the person from whom the copies of records may be obtained. The notice must appear at least once a week for 4 consecutive weeks.

59A-35.100 Minimum Licensure Requirements. Provider location. A licensee must maintain proper authority for operation of the provider at the address of record. If such authority is denied, revoked or otherwise terminated by the local zoning or code enforcement authority, the Agency may deny or revoke an application or license, or impose sanctions.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to inform the Agency not less than 30 days prior to the discontinuance of operation and inform clients of such discontinuance as required by authorizing statutes. No notice was provided to clients or the Agency.

Findings Include:

On . . . . . this surveyor conducted a closure monitoring survey at the facility.
During interview with employee #1 on . . . . . at 9:35 AM, employee 1 stated to the surveyor, "It was inhumane what they did to them. They just came and took them. They said AHCA was

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
	AL11943023	A. BUILDING: _____ B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

(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
CZ817	Continued From page 2 closing us, then we heard the owner made an agreement with some other people, (ALF)." During interview with the Assistant Administrator on [redacted] at 9:39 AM, the Assistant Administrator stated she doesn't know what was going on. "(ALF) came over here a day before yesterday and took everybody. We didn't know anything." She stated "(owner) made a deal with my boss. (Owner) did call and said that folks from (ALF) was coming to look at paperwork. Never said anything about moving people." This surveyor asked if she had a contact number for (Owner), which was provided. In addition, Assistant Administrator stated "(employee) from (ALF) just came in and started pulling files. They didn't give us anything. She used to work at this facility. Some of the residents knew her. We tried to call the real owner (Last name), but his number is disconnected." Additionally, she stated that the people from {facility} told them that AHCA told them they had to move. They just came in and grabbed folders. This surveyor asked for the contact information she had for the owner. During interview with employee #2 on [redacted] at 9:48 AM, employee 2 stated: "I had no idea. (Owner) obviously made arrangements with (ALF) to come and move people. She (Administrator) had no idea. She was totally bombarded. We had no idea that anybody was moving. The owner is no longer communicating with us." During interview with employee #3 on [redacted] at 10:12 AM, employee 3 stated "I overheard (ALF representative) telling the residents out here	CZ817		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943023	A. BUILDING: _____ B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

(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
CZ817	Continued From page 3	CZ817		

that if they did not get on the bus right now, they would not have anywhere to sleep, and she would not accept them for the money they would be paying, and she wasn't coming for them. That was their last chance. They got scared and went on the bus. There was 2 or 3 residents out there when she threatened to get them on the bus."

On at 10:00 AM this surveyor spoke with the Administrator to get an update on the status of all residents. She stated that she was totally unaware we were closing, we got no notice from them. There were "only seven (7) residents here presently." She stated she called the Agency upon learning of the closure.

This surveyor asked if there was a plan in place to attend to the needs of the residents if they had not moved. She stated "All I know is that they said ..." This surveyor asked again if there was a plan by the owners or the facility to provide services to any resident who had not been placed by today. She stated: "If the residents don't move today, there will be staff here to provide them services."

On at 10:18 AM this surveyor interviewed employee #4 who stated: "From what I know, Wednesday they came in around 12 lunch time. They came in, grabbed the charts. And another person went in the MORs and started making copies. When I realized he was making copies, I helped them out make copies." This surveyor asked if they provided any verification that they had permission to do so. She stated "They did not provide any documentation, no explanation, nothing. Just went in the books and started making copies." Employee #4 also stated she was passing out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943023	A. BUILDING: _____ B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

(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
CZ817	Continued From page 4	CZ817		

food and looked and saw them. States they (ALF) came in the afternoon during lunch and took 15 residents. "Then they came around 7:00PM and picked up 2 more." Employee #3 also stated: "All the case managers came. One of the persons (LTC Case Manager) I talked to said they got a phone call. It was packed in here yesterday. She states everyone took their meds. One of them took her but left her medication. But they (ALF) came yesterday and picked them up.

On at 10:38 AM: This surveyor observed a bus arrive to pick up residents. This surveyor introduced himself and asked the driver who he was and if he was here to pick up residents. He gave his name and the facility he was representing, and the residents he was picking up.

On at 10:47 AM: This surveyor observed two (2) individuals from (ALF) come in to the facility at 10:58 AM. This surveyor spoke with (facility representative). This surveyor asked if she had assessed anyone (residents), and is she taking anybody. She stated she is not taking anyone and left the facility.

On at 11:06 AM: This surveyor observed (driver from ALF) receiving Meds from the Assistant Administrator. Residents were boarded on their bus and waiting for him to board. Upon receiving the meds, he boarded the bus and drove off.

On at 11:16 AM, this surveyor spoke with (representative of Long-Term Care Organization). She stated that they have 27 Residents on their Plan. As of this time they had placed several and had 3 waiting to be picked up today"'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943023	A. BUILDING: _____ B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

(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
CZ817	Continued From page 5 On at 1:08 PM this surveyor spoke with (Representative of Long-Term Care Organization) who stated she contacted the facility to make sure her members were in the facility, not in the hospital or anything because I was going to do my LOC visits. When I called around 5:15 PM, I was told one of my members had moved to (ALF). That's when I learned that they were closing. When I called (ALF), they informed me that there was more than that one person, that there was more. They said that the building was being shut by the state." On at 2:22 PM: This surveyor observed representatives from (Long Term Care Organization) leaving the facility. This surveyor spoke with their Manager of Special Programs and requested a copy of the list or residents placed by them. On at between 3:45 PM and 4:16 PM: This surveyor observed a bus from (ALF) arrive to take the last remaining resident and his belongings on the bus. This surveyor went to the residents' room and observed the packing. This surveyor then observed them place most of resident's belongings on the bus. This surveyor observed as they loaded the resident (who was in a manual wheelchair) onto the bus on its hydraulic lift and watched as they drove away from the facility. On at 10:05 AM this surveyor made a call to the number provided for the owner of the facility and received a recorded message: "Welcome to (Provider) Wireless. The number you dialed has been changed, disconnected or is no longer in service. If you feel you has reached this number in error, please check the number	CZ817		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943023	A. BUILDING: _____ B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

(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
CZ817	Continued From page 6 and try your call again." Additional telephone calls were made to the number at 10:07 AM, 10:08 AM and 10:09 AM. The recorded message was received each time. On at 2:15 PM this surveyor telephoned (Ownership representative) and received a voicemail and left a detailed message. At the time of this submission no returned call has been received. On between 3:03 PM - 3:30 PM, this surveyor along with the Administrator and Assistant Administrator walked the entire facility. Each room of the two (2) story facility was thoroughly checked to determine if there were any resident remaining. A search of every room, including bathroom, closets, under beds and cabinets was conducted by this surveyor. There were no residents observed in any of the rooms. On at 4:20 PM this surveyor met with the Administrator and Assistant Administrator to conduct the Exit Interview. Both parties, confirmed that no noticie of closure had been given to the residents and that they were unable to reach the Owners. Unclassified	CZ817		