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
	AL11932406	A. BUILDING: _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENLEAF ASSISTED LIVING LLC	509 W. VERONA STREET KISSIMMEE, FL 34741

(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 Complaint Investigation #2020001583 was conducted on , , and . Greenleaf Assisted Living had deficiencies identified at the time of the visit. The facility failed to protect residents from unsafe conditions, placed the residents at risk of living in an environment ill-equipped to provide for resident health, safety and welfare due to lack of supervision and care, and placed residents in a facility where residents' safety and protection was repeatedly overlooked. These failures posed an immediate and serious danger to the public health, safety, and welfare of all the residents in the facility. As a result of these failures, resident #1 sustained over 60% of her body and subsequently .	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 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	A 025		

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A 025	Continued From page 1	A 025		

supervision as appropriate for each resident, including the following:
(a) Monitoring of the quantity and quality of resident diets in accordance with rule 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 review of resident records, facility records, adverse report, fire report, police report, hospital emergency department records, video from closed circuit cameras, and interviews, the facility failed to provide supervision to 2 of 29 residents identified as smoking inside the facility (#1 & 2). The facility failed to ensure that 1) the twenty nine residents identified as smokers were appropriately assessed to smoke, 2) failed to ensure that the residents smoked responsibly and safely, and were capable to maintain their

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A 025	Continued From page 2 smoking materials safely in their possession, and 3) failed to ensure that the facility provided safety and well-being of all the residents. Findings: The Agency for Health Care Administration (AHCA) received information on which indicated resident #1 was in bed smoking while wearing on . The concentrator caught on fire and the resident sustained over 60% of her body. The resident was taken to the local hospital, was intubated and then airlifted to a Level 1 Hospital unit. She expired on . During interviews with residents, staff and the administrator on between 10:50 AM and 11:15 AM, they all said that no one knew resident #1 smoked in her room. Some of the residents mentioned that resident #2 was caught smoking in the second-floor bathroom after the fire on . Upon arrival to the facility on at 10:50 AM, the administrator said residents received their allowance all at once and they would go out and buy whatever they wanted. She said resident #1 did not have a history of smoking in her room, was cognizant, and knew not to smoke while using . She was not in the facility on Saturday , the day of the fire. The staff called her to inform her of the fire. The staff completed the incident reports and she submitted the 1-day adverse report to AHCA. On at 11 AM, licensed practical nurse Q said the residents all kept their cigarettes and lighters because it was an assisted living facility and they had the right to do so. Resident #1 did	A 025		

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A 025	Continued From page 3 not have a history of smoking in her room documented in her record. Resident #1's record revealed an updated health assessment report (1823) dated [redacted] that listed a diagnosis of [redacted]. Per the 1823, the resident needed [redacted] 2 liters per minute as needed. She was independent in eating, supervision was needed with ambulation and transferring, and assistance was needed with bathing, grooming and toileting. She was admitted to hospice services on [redacted] with a diagnosis of [redacted]. Hospice ordered [redacted] at 2 liters per minute by [redacted] canula on [redacted]. There were no notations that indicated the resident, a known smoker, was monitored to ensure she did not smoke inside the building to ensure her safety and the safety of all the residents. A call was received on [redacted] at 4 PM from the detective who investigated the fire involving resident #1. The detective said he had viewed it and it was a "bottleneck", trying to get the residents out. He said staff lacked training and did not know what to do. The fire report, dated [redacted], was received by AHCA [redacted] and revealed that fire rescue received a call at 1:32 PM and arrived at the facility at 1:35 PM. They responded to a call for a report of a person on fire. Upon arrival, a nurse advised them that resident #1 was smoking a cigarette in her bed while using [redacted], and this caused an explosion. The nurse stated the resident was now in the hallway in a wheelchair. Air care was requested to meet at the local hospital via helipad due to the severity of the [redacted]. They advised that a crew was needed to	A 025		

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A 025	Continued From page 4 check for fire extension (spread of fire). The resident was transferred to a unit at the Level 1 . . . . 1 Orlando hospital. The local hospital emergency department (ED) report, dated at 2:40 PM, indicated resident #1 was brought in from the assisted living facility by emergency medical services. The chief complaint was . . injury from the resident smoking next to an . . . concentrator. It exploded and . . . . her torso, . . . , and extremities. She was brought to the ED for . . . . . prior to transport to the Level 1 . . . . Hospital unit. The physical exam indicated she was alert without . . . , ... , distress, had significant partial /full thickness to her which was blackened and had soot. There were anterior and , and significant . . . . . , anterior upper . . . , abdomen . . where fabric adhered to her skin, arms, ... , upper thighs and . . . . The resident required due to the extent of the ; 60-69% . . . , less than 10% were . . . . . . The diagnosis was blast injury/ , difficulty. The police department investigation report, dated and timed at 1:31 PM, was received on . . . . . It indicated the fire was accidental in nature. Per the report, multiple residents stated that resident #1 would often smoke inside her room while still using the . . . . The law enforcement officer, who investigated the scene, photographed a pack of cigarettes on the bed of resident #1's bed next to an . . . . concentrator, a highly flammable medical product. The closed-circuit video recording, received by the AHCA representative on at 11:30	A 025		

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A 025	Continued From page 5 AM, revealed that the staff did not follow the facility's fire and evacuation policy, as follows: On at 1:32 PM, two unidentified residents entered the building and were about to take the elevator. Staff C opened the door to . . # and staff B came to resident #7's room. The 2 residents waiting for the elevator went to see what was going on. One resident in a wheelchair and one other resident, who was walking, passed by . . # and leave the area. Another unidentified resident with a walker came by . . # to see what is going on. Staff D passed by this resident quickly. Two other unidentified residents in wheelchairs, and one calmly walking past # , get entangled with staff B, who had a cell phone in her . These residents toward the exit and out of view and staff B passed by them. The resident with the walker remained by . . # . Staff did not speak to her, move her away from the fire in # , or assist her to evacuate. Another unidentified resident comes out of . . # . At 1:26 PM, black smoke was seen in the hallway. The smoke was darker and heavier. Staff A went . . . toward the smoke. At 1:27 PM, staff B wheeled resident #1 from # room in a wheelchair and placed her in the hallway outside . . # . . The resident with the walker remained standing by the door of # while resident #1, who had flames on the . . . . of the wheelchair and on her , , was brought out of . . # . The resident's clothing and wheelchair were on fire. Staff C ran toward resident #1 with a pitcher of water. There was thick black smoke in the hallway. Staff B left the resident alone in the hallway. Resident #1 attempted to , out the fire on her , . The	A 025		

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A 025	Continued From page 6 resident in . . . # had no yet evacuated. At 1:28 PM, staff B returned with 2 pitchers of water, and poured the water on resident and wheelchair and left again. The resident reached for a walker which was next to her in the hallway but was unable to reach it. Staff A brings more water. Another unidentified resident walked by resident #1 in the hallway, covering her . . . and . She had a fire extinguisher in her . . but the extinguisher was not used. At 1:29 PM, the unidentified resident with a walker was assisted out of the facility without the walker. Police officers arrived. The fire was smoldering on resident #1's wheelchair. The police officer removed some clothing from the of her wheelchair and poured water on the chair. At 1:31 PM, staff A went . . . into smoky area toward resident #1's room. The police officer stayed with resident #1 and spoke with her. In the view, staff A was tossing clothing on the floor. Two other unidentified residents in wheelchairs came out into view; one self-propelled and the other was wheeled by the staff. At 1:32 PM, a second police officer entered the scene and noticed a resident in . . . # . . He gestured for staff A, who came into # and left. Shortly after, a male resident with a walker ambulated out of # alone. Staff did not guide him to evacuate. He passed resident #1 who was still in the hallway. On , pictures received from the law enforcement officer revealed a pack of cigarettes on the bed of resident #1 and a	A 025		

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A 025	Continued From page 7 concentrator on the side of the bed. The mattress had a large hole in it, and the bed springs were visible. Per video, the resident in the hallway with the walker evacuated in 5 minutes, the 2 residents in wheelchairs evacuated in 6 minutes, and the resident in # evacuated in 7 minutes. The facility did not use a fire extinguisher to put out the fire and did not comfort resident #1. They left her alone in the hallway while getting pitchers of water to put out the fire on her and her wheelchair. The facility did not evacuate all of the residents in the building. The staff failed to follow their emergency training, thereby endangering the residents. Review of the facility's Fire Plan, dated . . . . . , revealed the R.A.C.E. steps for when a fire is detected. "R" stands for "Remove anyone in immediate danger to a safe area away from the fire.... the assistant administrator will log the residents, making sure everybody is accounted for." Staff did not ensure that all residents were removed, logged and accounted as safe during and after the fire on . . . . The Fire Safety Plan read in part, "In the event of fire, the highest-ranking fire officer has the authority to direct all operations including the evacuation of the facility. The administrator or designee will be in charge of directing firefighting efforts of fire containment before the firemen arrive. The administrator will order which residents to evacuate first." Evacuation procedures include: "Safe zones would be outside of the building, opposite the side of the fire area...." According to the video on the day of the fire, it could not be determined who was in charge of fire containment and evacuation.	A 025		

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A 025	Continued From page 8 Review of the fire drill documentation from [redacted] and [redacted] revealed the staff checklist included documentation of the location of the fire, where residents were to evacuate to, exits used, and if the fire alarms, extinguishers, smoke detectors and emergency lights were operational. The fire drill report form did not contain any way for staff to document if residents were moved to safety, accounted for, or if resident rooms were checked during an evacuation. (Photographic evidence obtained.) Interviews with additional residents and staff were done on [redacted] between 10:45 and 2:15 PM. Several residents and staff said that residents #2 was in the habit of smoking inside that facility and it was common knowledge. The following are their identifiers. At 10:45 AM, resident #3 said she shared a room with resident #7. She said she used [redacted] at bedtime but has not used it since the fire on [redacted] because she was scared that resident #7 would still smoke sometimes in the bathroom. She said the housekeeper found cigarette ashes in the toilet in their room. Resident #3 said she was scared to reside in the room with resident #7 and had unplugged her [redacted] concentrator. At 11 AM, residents #5 and #9 said they would smell smoke in the hallway at times where resident #1 resided but did not know where the smoke came from. At 11:05 AM, resident #23 who said he knew resident #2 smoked inside. He did not know if he was given a discharge notice. He said that he and resident #6 caught resident #2 smoking in the bathroom. He stated, "We told the staff	A 025		

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A 025	Continued From page 9 several times." At 11:10 AM, resident #8 stated that staff found her husband, resident #2, smoking in the bathroom several times. She stated that he signed a letter not to smoke inside a few days ago. At 11:30 AM, resident #30 stated she feared " ◡ up". She stated that residents #2 and #16 still smoke in the building. At 11:30 AM, resident #27 stated that no one could smoke in their room. Resident #27 said he participated in a fire drill the day before the fire last week. At 11:38 AM, resident #6 stated that resident #2 has been caught smoking in the bathroom several times. Resident #6 also stated that resident #1 was a smoker. At 11:40 AM, resident #13 stated there are people who smoke inside, but nothing ever happens, just a slap on the ... She said she used to room with resident #1. She told the administrator "hundreds of times" that resident #1 was smoking in the room. She said, "I complained enough that I was given a new room, but resident #1 kept smoking." Resident #13 said she heard the alarm on ..... and got herself out of her room in her wheelchair. She stated resident #2 "still smokes in the building. He's been told, but he doesn't listen. [Resident #2] was caught smoking in the hallway restroom four times the very next day and nothing was done." At 11:42 AM, resident #32 said that she knew resident #2 smoked in the room.	A 025		

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A 025	Continued From page 10	A 025		

At 11:45 AM, resident #14 stated she knew that resident #2 "smokes in the bathroom and elevator. He's been told about it many times."

At 12:20 PM, resident #25 said resident #1 was her roommate for 3 years. She stated, "I repeatedly told the administrator that [resident #1] was smoking. I was afraid because we both had [illegible] concentrators. I finally told her if she didn't do something, I would." She stated she was given a new room. She said she knew resident #1 continued to smoke with new roommates. She said that at the time of the fire, resident #1's roommate had [illegible]. She said "I heard the alarm but ignored it. I thought it was another drill. [Staff A] banged on my door and helped me get a blanket on but went [illegible] to help with [resident #1]. I got out in my wheelchair. There was smoke everywhere. I was one of the last people evacuated." She identified that residents #2 and #16 still smoke inside. Resident #25 said she is still scared there will be another fire.

At 1:07 PM, resident #29 said he knew resident #2 smoked inside the building and had been given notice.

At 1:26 PM, resident #7 said resident #2 and resident #1 smoked in their room, "Everybody knew about it."

At 1:45 PM, resident #15 stated she knew resident #2 still smoked inside the facility.

At 1:57 PM, staff D heard that resident #2 smoked indoors. He had never seen resident #2 smoking inside the building. He heard that staff spoke to him about the smoking.

At 2:10 PM, staff N said that resident #2 was

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A 025	Continued From page 11 known to smoke inside. She knew resident #1 smoked in her room, told the administrator, several times and nothing was done about it. Resident #2's record revealed an admission date of . The 1823, dated , listed a diagnosis of . He was alert and oriented to name and place only, not to time. On , staff found him smoking in the upstairs bathroom. Staff gave him a verbal warning, telling him that any further smoking will result in a 45-day notice to discharge. On , a follow-up meeting about smoking, and the rules were read, and he stated he understood. There was no evidence that the resident was given a 45-day discharge notice as per the facility smoking policy for smoking in the bathroom on , the day after the fire. The Resident Agreement page 11 item 6 indicated the smoking policy which read, "Smoking is permitted within the designated area only. No smoking is allowed inside the building, this includes resident apartments, common areas and bathrooms. Failure to follow this community policy may result in termination of Agreement." The facility did not have a system in place to ensure that residents who smoked inside the facility were closely monitored, that the facility's smoking policy was followed, a 45-day notice to discharge was not given, although resident #2 was caught smoking in the second floor bathroom the very next day after the fire. This lack of a safety system to monitor residents who smoke allowed resident #1 to smoke in her room while using , thus causing an explosion, fire, over 60% of her body, and her subsequent on .	A 025		

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A 025	Continued From page 12 Class I	A 025		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all	A 077		

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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 077	Continued From page 13 residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if	A 077		

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
	AL11932406	A. BUILDING: _____ B. WING _____	02/05/2020

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A 077	Continued From page 14	A 077		

the facility maintains licensure as an extended congregate care or limited mental health facility.
(c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.
(d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not . . . . . , serve as an administrator of any other facility.
(e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, ... , which is incorporated by reference and available online at:
http://www.flrules.org/Gateway/reference.asp?No=Ref-09393.

This Statute or Rule is not met as evidenced by:

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A 077	Continued From page 15 Based on interviews, resident record reviews, Resident Agreement, hospital emergency room (ED) report, fire rescue report, and the police report, the administrator, who was responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents, did not: 1) assess the 29 residents, identified as smokers, to ensure their appropriateness to smoke safely. The facility failed to monitor the residents who were identified as smokers to ensure the safety and well-being of the other 30 residents who resided in the facility. 2) ensure staff were able to perform their assigned duties consistent with their level of training, preparation, and experience, and did not implement the fire safety plan's evacuation directives in order to protect residents from an ongoing fire within the Facility. 3) always honor the residents' rights to ensure all residents felt safe while on the premises, and failed to have a system in place to monitor ,, equipment that was in the proximity of the residents who smoke. Findings: The Agency for Health Care Administration (AHCA) received information on which indicated resident #1 was in bed smoking while wearing ,, on . The ,, concentrator caught on fire and the resident sustained over 60% of her body. The resident was taken to the local hospital, was intubated and then airlifted to a 1 Hospital unit. She expired on . On , interviews were conducted with the following staff and residents:	A 077		

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A 077	Continued From page 16 At 10:50 AM, the administrator said the residents got their allowance all at one time and they go out and buy what they want. Staff did not document and identify what the residents were bringing into the facility. She said resident #1 did not have a history of smoking in her room, was cognizant, and knew not to smoke while using . . . At 11 AM, licensed practical nurse Q stated all the residents keep their cigarettes and lighters, that the residents live in an assisted living facility and have the right to keep their own cigarettes and lighters. At 11:05 AM, resident #7 said he knew resident #2 smoked inside the building. At 11:15 AM, resident #5 stated resident #2 smoked inside the facility. At 11:15 AM, resident #6 stated resident #2 smoked inside the building. Review of the facility's Resident Agreement page 11 item 6 indicated the following smoking policy: "Smoking is permitted within the designated area only. No smoking is allowed inside the building, this includes residents' apartments, common areas and bathrooms. Failure to follow this community policy may result in termination of Agreement." Resident #1's record revealed an updated health assessment report (1823) dated . . . . that listed a diagnosis of . . . . . (. . .). Per the 1823, the resident needed . . 2 liters per minute as needed. She was independent in eating, supervision was needed with ambulation and	A 077		

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A 077	Continued From page 17 transferring, and assistance was needed with bathing, grooming and toileting. She was admitted to hospice services on . . . . . with a diagnosis of . Hospice ordered , at 2 liters per minute by . . . canula on . . . . There were no notations that indicated the resident, a known smoker, was monitored to ensure she did not smoke inside the building to ensure her safety and the safety of all the residents. The closed-circuit video recording, received by the AHCA representative on at 11:30 AM, revealed that the staff did not follow the facility's fire and evacuation policy, as follows: On . . . . . at 1:32 PM, two unidentified residents entered the building and were about to take the elevator. Staff C opened the door to # and staff B came to resident #7's room. The 2 residents waiting for the elevator went to see what was going on. One resident in a wheelchair and one other resident, who was walking, passed by # and leave the area. Another unidentified resident with a walker came by # to see what is going on. Staff D passed by this resident quickly. Two other unidentified residents in wheelchairs, and one calmly walking past . . # , get entangled with staff B, who had a cell phone in her . These residents . . . toward the exit and out of view and staff B passed by them. The resident with the walker remained by . . # . Staff did not speak to her, move her away from the fire in . . # , or assist her to evacuate. Another unidentified resident comes out of # . At 1:26 PM, black smoke was seen in the hallway. The smoke was darker and heavier. Staff A went toward the smoke.	A 077		

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A 077	Continued From page 18 At 1:27 PM, staff B wheeled resident #1 from # room in a wheelchair and placed her in the hallway outside # . The resident with the walker remained standing by the door of # while resident #1, who had flames on the of the wheelchair and on her , , was brought out of # . The resident's clothing and wheelchair were on fire. Staff C ran toward resident #1 with pitcher of water. There was thick black smoke in the hallway. Staff B left the resident alone in the hallway. Resident #1 attempted to , out the fire on her , . The resident in # had no yet evacuated. At 1:28 PM, staff B returned with 2 pitchers of water, and poured the water on resident and wheelchair and left again. The resident reached for a walker which was next to her in the hallway but was unable to reach it. Staff A brings more water. Another unidentified resident walked by resident #1 in the hallway, covering her and . She had a fire extinguisher in her At 1:29 PM, the resident with a walker was assisted out of the facility without the walker. Police officers arrived. The fire was smoldering on resident #1's wheelchair. The police officer removed some clothing from the of her wheelchair and poured water on the chair. At 1:31 PM, staff A went into smoky area toward resident #1's room. The police officer stayed with resident #1 and spoke with her. In the view, staff A was tossing clothing on the floor. Two other unidentified residents in wheelchairs came out into view; one self-propelled and the other was wheeled by the staff.	A 077		

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A 077	Continued From page 19 At 1:32 PM, a second police officer entered the scene and noticed a resident in . . # . . He gestured for staff A, who came into # and left. Shortly after, a male resident with a walker ambulated out of # alone. Staff did not guide him to evacuate. He passed resident #1 who was still in the hallway. Per video, the resident in the hallway with the walker evacuated in 5 minutes, the 2 residents in wheelchairs evacuated in 6 minutes, and the resident in . . # . evacuated in 7 minutes. On . . . . . , pictures received from the law enforcement officer revealed a pack of cigarettes on the bed of resident #1 and a . . . . . concentrator on the side of the bed. The mattress had a large . . hole in it, and the bed springs were visible. Review of the facility's closed-circuit video on . . . . . at 10:30 AM did not reveal any staff entering and leaving any other resident rooms on the first floor. Staff A, B and C on the first floor were not seen on video taking residents to safety. Residents were viewed going to see where the fire was in # . The staff did not evacuate all of the residents in the building. Residents were not seen being asked to evacuate. Staff were not seen checking rooms on the first floor to ensure residents had evacuated. Staff were not seen bringing a fire extinguisher to the fire. Although a fire extinguisher was available, staff were not seen attempting to retrieve and use it. A resident brought it over to the staff, but they did not use it to put out the fire. Staff did not comfort resident #1 but left her alone in the hallway while on fire to get pitchers of water to put out the fire on her and her wheelchair. The staff failed to follow their	A 077		

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A 077	Continued From page 20 emergency training, thereby endangering the residents. Review of the police department investigation report, dated and timed at 1:31 PM, was received on . It indicated the fire was accidental in nature. Per the report, multiple residents stated that resident #1 would often smoke inside her room while still using the . The law enforcement officer who investigated the scene photographed a pack of cigarettes on the bed of resident #1's bed next to an concentrator, a highly flammable medical product. In pictures taken on by the police detective who investigated the fire, a pack of cigarettes can be seen on resident #1's bed and an concentrator on the left side of her bed. Resident #2's record revealed an admission date of . The 1823, dated , listed diagnoses of bi-polar , and . The resident was assessed to be alert to person and place but not to time. Resident #2's record revealed the following facility notes: - Caught smoking in the upstairs bathroom, staff went to him and gave him a verbal warning, any further smoking will result in a 45-day notice - Follow-up meeting about smoking, rules read; he stated he understood - Follow-up with resident to remind him how important it is to follow rules. He said he understood. Staff will continue to monitor. - Said was "not smoking in building".	A 077		

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A 077	Continued From page 21 Resident #2's record revealed a no smoking letter signed and dated on . . . . . The last facility's notes reflected that on , resident was not smoking in the room. (Photographic evidence obtained.) On at 11:05 AM, resident #23 said he knew that resident #2 smoked inside. He said resident #2 was caught smoking in bathroom. He said that he told the staff several times about resident #2 smoking inside the building, but he had continued to smoke inside the building. On . . . . . at 11:10 AM, resident #8 stated that staff founs her husband, resident #2, smoking in the bathroom several times. She stated that he signed a letter a few days ago not to smoke inside. On . . . . . at 1:45 PM, resident #15 stated she knew resident #2 still smoked inside the facility. On at 11:42 AM, resident #32 said she knew resident #1 smoked in her room. On . . . . . at 1:07 PM, resident #29 said he knew resident #2 smoked inside the building and had been given a notice not to smoke inside the building. On at 1:26 PM, resident #27 said resident #2 smoked in her room. She stated that resident #1 smoked in her room. She said, "Everybody knew about it." On . . . . . at 1:37 PM, resident #21 said resident #2 smoked inside the building. On at 1:57 AM, staff D said he knew	A 077		

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A 077	Continued From page 22 resident #2 smoked inside the building. He explained that he heard about it, but staff spoke to her about it. On . . . . . at 2:15 PM, staff N said resident #2 smoked inside the building, and knew resident #1 also smoked in the room. She stated that she had made the administrator aware of this. On at 10:45 AM, resident #3 said she shared a room with resident #7. She said she had to use at bedtime but did not use it since the fire on . . . . . She said she was scared because resident #7 would still smoke sometimes in the bathroom. She said the housekeeper found cigarette ashes in the toilet. Resident #3 said she was scared to reside in the room with resident #7. She stated she had unplugged her concentrator. On . . . . . at 11 AM, residents #5 and #9 both said they would smell smoke in the hallway at times where resident #1 resided but they did not know where the smoke came from. On at 11:30 AM, resident #30 stated she was still scared of " up". She stated resident #2 and resident #16 still smoke in the building. On . . . . . at 11:40 AM, resident #13 stated there are people who smoke inside, "but nothing ever happens- just a slap on the ." She said she used to room with resident #1. She told the facility administrator "hundreds of times that [resident #1] was smoking. I complained enough that I was given a new room but [resident #1] kept smoking." She stated resident #2 "still smokes in the building. He's been told, but he doesn't listen. Resident #2 was caught smoking in the hallway	A 077		

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A 077	Continued From page 23 restroom 4 times the very next day [ ] and nothing was done." On at 11:45 AM, resident #14 stated she knew that resident #2 "smokes in the bathroom and elevator. He's been told about it many times." On at 12:20 PM, resident #25 said resident #1 was her roommate for 3 years. She said, "I repeatedly told the administrator that [resident #1] was smoking. I was afraid because we both had concentrators. I finally told her if she didn't do something, I would." She stated she was given a new room. She said she knew resident #1 continued to smoke with new roommates. She said, "I heard the alarm, but ignored it. I thought it was another drill. [Staff A] banged on my door and helped me get a blanket on but went to help with [resident #1]. I got out in my wheelchair. There was smoke everywhere.... I was one of the last people evacuated." She identified residents #2 and #16 who still smoke inside the building. Resident #25 said she is still scared there will be another fire. On at 11:38 AM, resident #6 stated that staff had seen resident #2 smoking in the bathroom several times. Resident #6 also stated that resident #1 was a smoker. The facility did not have a system in place to ensure that residents who smoke were closely monitored to ensure the safety of all residents in the facility. There were no policies and procedures in place to monitor and assess residents who smoke and their ability to self-maintain smoking materials safely.	A 077		

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A 077	Continued From page 24 Review of the staff schedule for revealed staff A, B, C, and D worked in the facility on the date and time of the fire, . Their personnel records revealed that they had received training on the facility's policies and procedures for emergencies and evacuation, the fire plan and fire extinguisher training. Review of the facility's Fire Plan, dated , revealed the R.A.C.E. steps for when a fire is detected. "R" stands for "Remove anyone in immediate danger to a safe area away from the fire.... the assistant administrator will log the residents, making sure everybody is accounted for." Staff did not ensure that all residents were removed, logged and accounted as safe during and after the fire on . The Fire Safety Plan read in part, "In the event of fire, the highest-ranking fire officer has the authority to direct all operations including the evacuation of the facility. The administrator or designee will be in charge of directing firefighting efforts of fire containment before the firemen arrive. The administrator will order which residents to evacuate first." Evacuation procedures include: "Safe zones would be outside of the building, opposite the side of the fire area...." According to the video on the day of the fire, it could not be determined who was in charge of fire containment and evacuation. Review of the fire drill documentation from and revealed the staff checklist included documentation of the location of the fire, where residents were to evacuate to, exits used, and if the fire alarms, extinguishers, smoke detectors and emergency lights were operational. The fire drill report form did not contain any way for staff to document if residents	A 077		

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A 077	Continued From page 25 were moved to safety, accounted for, or if resident rooms were checked during an evacuation. (Photographic evidence obtained.) A review of the fire report, dated [redacted], was received by AHCA and revealed that fire rescue received a call at 1:32 PM and arrived at the facility at 1:35 PM. They responded to a call for a report of a person on fire. Upon arrival, a nurse advised them that the victim was smoking a cigarette in her bed while using [redacted], and this caused an explosion. The nurse stated the resident was now in the hallway in a wheelchair. Air care was requested to meet at the local hospital via helipad due to the severity of the [redacted]. They advised that a crew was needed to check for fire extension (spread of fire). The resident was transferred to a [redacted] unit at the [redacted] 1 Orlando hospital. The local hospital emergency department (ED) report dated [redacted] at 2:40 PM indicated resident #1 was brought in from the assisted living facility by emergency medical services. The chief complaint was [redacted] injury from the resident smoking next to an [redacted] concentrator. It exploded and [redacted] her torso, [redacted], and extremities. She was brought to the ED for [redacted] prior to transport to the Level 1 [redacted] Hospital [redacted] unit. The physical exam indicated she was alert without [redacted] distress, had significant partial /full thickness [redacted] to her which was blackened and had soot. There were anterior and [redacted] and significant [redacted], anterior upper [redacted], abdomen [redacted] where fabric adhered to her skin, [redacted] arms, [redacted], upper thighs and [redacted]. The resident required [redacted] due to the extent of the [redacted]: 60-69% [redacted], less than 10% were [redacted]. The diagnosis was blast injury/ [redacted]	A 077		

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A 077	Continued From page 26 difficulty. Review of the police department investigation report, dated and timed at 1:31 PM, was received on . It indicated the fire was accidental in nature. Per the report, multiple residents stated that resident #1 would often smoke inside her room while still using the . The law enforcement officer who investigated the scene photographed a pack of cigarettes on the bed of resident #1's bed next to an concentrator, a highly flammable medical product. The facility did not have a system in place to ensure that residents who smoked were closely monitored to ensure the safety of all the residents in the facility. On between 11 AM and 11:30 AM, residents #5 and #7 both said resident #2 was caught smoking in the bathroom after the fire. The administrator did not oversee the operations and management of the Assisted Living Facility. On at 1:25 PM, resident #1 smoked a cigarette in her room while using which caused the concentrator to explode. Resident #1 sustained to over 60% of her body, was airlifted to a Level 1 Hospital unit. She expired on . On , the very next day after the fire, resident #2 was caught smoking inside the building in the 2nd floor bathroom. The administrator once again did not follow the smoking policy and did not issue a 45-day notice of discharge and rather gave the resident a verbal warning. The administrator did not assess the 29 smokers for appropriateness to smoke safely.	A 077		

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	AL11932406	A. BUILDING: _____ B. WING _____	02/05/2020

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A 077	Continued From page 27 The administrator allowed all residents who smoked to keep all smoking materials on their person or in their room. Interviews with residents and staff revealed the administrator was aware that resident #1 occasionally smoked in her room, and resident #2 smoked inside the building. There was no evidence to confirm that the administrator followed the smoking policy and issue a 45-day discharge notice to move out to residents who smoke inside the building. The administrator did not have any evidence to confirm that monthly training specified in their fire plan was followed. During the fire on , several residents were allowed to stand around and observe the victim on fire. Staff did not direct them to evacuate as required. Several residents evacuated independently after the fire was extinguished and the fire department had arrived. Staff were not observed checking rooms on the first floor. Staff were not observed bringing a fire extinguisher to the fire. The administrator did not ensure that staff performed their assigned duties consistent with their level of training, preparation, and experience, and did not implement the fire safety plan's evacuation directives in order to protect residents from an ongoing fire within the facility. During interviews with residents on , it was revealed that after the fire on , the administrator did not interview the residents about concerns with their safety and the possibility of another fire. The administrator did not have any documentation to confirm that residents who smoked and had equipment in their	A 077		

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A 077	Continued From page 28 vicinity were monitored to ensure that all the residents of the facility felt safe. The administrator did not have a system in place to monitor [illegible] equipment of residents who were known smokers. The administrator did not honor residents' rights by not ensuring they felt safe while in the facility. Class I	A 077		
A 078 SS=J	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable [illegible]. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative [illegible] examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual [illegible] examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of [illegible]. 2. If any staff member has, or is suspected of having, a communicable [illegible], such individual	A 078		

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A 078	Continued From page 29 must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, review of the facility fire	A 078		

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A 078	Continued From page 30 plan, fire drill, closed-circuit video, and personnel record review, the facility failed to ensure staff were able to perform their assigned duties consistent with their level of training, preparation, and experience, and did not implement the fire safety plan's evacuation directives in order to protect residents from an ongoing fire within the facility for 4 of 4 sampled staff (A, B, C & D). Findings: Review of the staff schedule for revealed staff A, B, C and D worked in the facility on at 1:25 PM, at the time of the fire. Resident #1 was smoking in her room while using an concentrator. This resulted in an explosion and a fire in resident #1's room. Resident #1 was airlifted to a 1 Level Hospital in Orlando where she expired on . Review of the personnel record revealed that all of the staff present on , A, B, C and D, received training on the facility's policies and procedures for emergencies and evacuation, the fire plan and fire extinguisher training. Staff A, caregiver, received training on the facility's emergency procedures on . Staff B, caregiver, received training on the facility's emergency procedures on . Staff C, caregiver, received training on the facility's emergency procedures on . Staff D, cook, received training on the facility's emergency procedures on . Review of the facility's fire plan, dated , revealed the R.A.C.E. steps for when a fire is detected. "R" stands for "Remove anyone in immediate danger to a safe area away from the	A 078		

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A 078	Continued From page 31 fire." The plan further stated, "the assistant administrator will log the residents, making sure everybody is accounted for." Annex A in the fire plan documented "in-services regarding fire safety and disaster plans will be done every first Wednesday of each month = use of fire extinguisher, confining and securing area in case of fire." There was no evidence the facility provided the monthly training specified in their fire plan. Review of the fire drill documentation from [redacted] and [redacted] revealed the staff checklist included documentation of the location of the fire, where residents were to evacuate to, exits used, and if the fire alarms, extinguishers, smoke detectors and emergency lights were operational. Staff A, B, C and D were documented to have attended this training. The fire drill report form did not contain any way for staff to document if residents were moved to safety, accounted for, or if resident rooms were checked during an evacuation. (Photographic evidence obtained.) Observation of the facility's closed-circuit video from the fire on [redacted] on [redacted] at 10:30 AM revealed no staff entering and leaving any other resident rooms in the first-floor hallway. Staff A, B and C on the 1st floor were not seen evacuating residents to safety. Residents were observed going to see where the fire was. No residents were seen being asked to evacuate. No staff were observed checking rooms visible in the first floor hallway. No staff were observed bringing a fire extinguisher to the fire. Review of the facility's closed-circuit cameras from [redacted] revealed the following: On [redacted] at 1:25 PM, two unidentified residents entered the facility and were about to take the	A 078		

Agency for Health Care Administration

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A 078	Continued From page 32	A 078		

elevator. Staff C opened the door to # and staff B came to # . The two residents waiting for the elevator went to see what was going on. One resident in a wheelchair and one, who was walking, passed by the # , which had the fire. Then, all four residents were not seen on the video. Another unidentified resident with a walker came by # to see what was going on. Staff D quickly passed by the resident with the walker. Two other unidentified residents in wheelchairs and 1 calmly walked past the room with the fire and walked to the exit. Staff B passed by them with a cell phone in her . The resident with the walker remained by # . Staff did not speak to her, move her away from the room with the fire, or assist her to evacuate. Another unidentified resident exited from # .

At 1:26 PM, thick black smoke was seen in the hallway. The smoke was darker and heavier. Staff A went toward the smoke.

At 1:27 PM, staff B wheeled resident #1 out of # . She was in a wheelchair. Staff C ran with a pitcher of water. The resident with a walker remained standing by door to # , even while resident #1 was brought out of the room. The clothing of resident #1 and the wheelchair were on fire with flames. Staff B placed resident #1 near the elevator, dining room and # , where the resident who lived in that room had not yet evacuated. The door of # was ajar. There was thick black smoke. Staff B left resident #1 alone in the hallway while the fire continued on her wheelchair and self. Resident #1 attempted to , the fire on her , . The resident in # had not yet evacuated.

At 1:28 PM, staff B returned with 2 pitchers of

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A 078	Continued From page 33 water and poured water on resident #1 and her wheelchair. There was a walker nearby. The resident reached for the walker but was unable to reach it. Staff A brought more water. Another unidentified resident walked by, covering her and . She held a fire extinguisher in her . . At 1:29 PM, the resident with the walker who stood by # was finally assisted out of the facility without the walker. The walker was left behind. Police officers arrived. Resident #1 was smoldering . He removed some clothing from of the wheelchair and poured water on the chair. At 1:31 PM, staff A went into the smoky area toward resident #1's room. The police officer stayed with resident #1 and spoke to her. In the view, staff A tossed clothing out of the way in the hallway. Two more unidentified residents in wheelchairs, one self-propelled, the other wheeled by the staff, were evacuated. At 1:32 PM, another police officer entered the scene, noticed a resident in # . He gestured for staff A, who came into # and quickly left. Shortly after, a male resident walked out of # , using a walker to ambulate. Staff did not guide him to evacuate. He had to pass by resident #1, who was still in the hallway. Incident investigation report from the local police department, dated Saturday at 1:31 PM, reflected that the fire was accidental in nature. Per report, multiple residents stated that resident #1 would often smoke inside her room while using , . In pictures taken on by the police	A 078		

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A 078	Continued From page 34 detective who investigated the fire, a pack of cigarettes was seen on the resident's bed as well as an [illegible] concentrator on the left side of the bed. Although a fire extinguisher was available, staff did not attempt to retrieve and use it. A resident brought it over to the staff, but she did not use it. Review of the video did not show that staff attempted to evacuate the residents, per their facility's fire plan. They allowed residents to stay around # , where the fire was. They did not supervise the other residents as they passed resident #1, who was on fire, in the hallway, to protect them from getting [illegible]. Class I	A 078		