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 _____	07/23/2022

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 Investigations #2022010596 and #2022008606 were conducted from . . . . . through . Allegation for Complaint Investigation #2022010596 was substantiated, and deficiencies were identified at the time of survey.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. 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 supervision as appropriate for each resident, including the following:	A 025		

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 _____	07/23/2022

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 025	Continued From page 1 (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 observation, interview and record review, the facility failed to provide care and services appropriate to meet the needs of residents by failing to monitor the general health, safety, and physical well-being of 13 of 13 residents whose room temperatures exceeded 81 degrees (°) Fahrenheit (F) (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 & #13). Findings: On at 9:08 AM during a facility tour, the second-floor common area was noted to be	A 025		

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 _____	07/23/2022

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 025	Continued From page 2 warm. Three portable air conditioner (A/C) units were set up in the hallway with heat exhaust vents going up through the ceiling tiles into the ceiling. On at 9:15 AM, the Administrator stated that one of the A/C units was not working. Ten rooms, 21, 23, 25, 26, 27, 28, 29, 32, 41, and 42, were affected by the A/C outage and the rooms were warm. Fans were seen in these resident rooms on at approximately 9:15 AM. On at 9:27 AM, resident #1 said his room was very warm. A round fan on a stand was observed in his room. He said the air conditioning had been out since last week. He said he felt fine and could go to the dining room and get ice and water any time. On at 9:40 AM, resident #2 said his room was warm. A box fan was observed in his room. He said the air conditioning had been out for 3 or 4 days. He said he felt alright, and the heat had not made him ill. On at 9:48 AM, resident #3 said his room was hot. A box fan was observed on the dresser. The resident said he felt okay. On at 9:53 AM, resident #4 said his room was very warm. A box fan was not observed in the room. The resident said the air-conditioning had been out for about a week. He said he felt fine and had not been ill. At 9:58 AM, the Administrator provided a box fan for resident #4. On at 9:45 AM, staff A said the facility had been working on the air-conditioning all last week.	A 025		

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 _____	07/23/2022

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 025	Continued From page 3 She said everyone had a fan in their room, and staff asked the residents to keep their doors open so air could circulate, but some of the residents still closed their doors. On at 10 AM, resident #5 was seated just outside his room and said his room was hot. He said he felt fine. A fan was observed in the doorway facing out. He said he was trying to vent the hot air out. On at 10:15 AM, the Administrator and the Maintenance Director acknowledged they did not have a thermometer in the building to check the air temperature in rooms where residents were affected by the A/C units. On at 12:30 PM, staff A said she had been doing rounds on the second floor at least every hour. She said they had not documented residents' status and room checks. She said staff B was doing most of the checks because she was working upstairs. She said she had been encouraging water, but most of the residents did not want it because they had their own cups with juice or water. She said she especially checked on resident #4 because he wore a lot of clothes, and he would not leave his door open. On at 12:35 PM, staff B said everyone upstairs was checked at least hourly. She said if she did not see the residents downstairs or in the hallways, she would go to their room and check on them. She said she has been encouraging the residents to drink fluids. She said there was ice, juice, and water always available downstairs in the dining room for the residents. On at 1:20 PM, the Administrator said they had purchased a handheld	A 025		

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 ______	07/23/2022

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 025	Continued From page 4	A 025		

thermometer. The Administrator then took temperatures of the following areas:
Hallway outside of - temperature was 87.4°F
Inside , resident #1's room - temperature was 88.5°F
Hallway outside - temperature was 82.5°F
Temperature in , resident #5's room - temperature was 86°F
Temperature in , resident #6's room - temperature was 87°F
Temperature in , resident #2's room - temperature was 85.4°F
Temperature in , resident #11's room - temperature was 84.7°F
Temperature in , resident #7's room - temperature was 86°F
Temperature in , resident #8's room - temperature was 88.5°F
Temperature in , resident #12's room - temperature was 86°F

On at 2 PM, staff C said she worked the 11 PM- 7 AM shift on . She said she was aware of the air-conditioning being broken. Staff C said she did the resident hourly checks and asked the residents to leave their doors open so air could flow. Some residents still wanted their doors closed. She said all the residents were fine and none felt ill.

On at 2:40 PM, staff D said he was aware of the air-conditioning being out. He said it had been out since last week. He said he had been doing hourly checks on the residents and asked them to leave their doors open to circulate the air. He said he did not document the resident rounds and said all the residents were okay with no distress or illness.

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 _____	07/23/2022

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 025	Continued From page 5 On at 3 PM, staff E said she had been doing hourly checks on the residents since the air conditioning went out last week. She said she did not document the resident checks and offered the residents water. She said none of the residents were ill or complained of feeling bad. Resident #3's record revealed he was admitted on . The 1823 Resident Health Assessment form, dated , indicated the resident was oriented to person and place. The resident's diagnoses included , , , , , , , and . Resident #2's record revealed he was admitted on . His 1823 Resident Health Assessment form, dated , indicated the resident was alert and oriented. His diagnoses included , , , , , and 's . Resident #8's record revealed he was admitted on . His 1823 Resident Health Assessment form, dated , indicated the resident was alert, and oriented. His diagnoses included carotid , , , , and . Resident #10's record revealed he was admitted on . His 1823 Resident Health Assessment form, dated , indicated the resident was alert and oriented. His diagnoses included , , , , , , and failure. Resident #1's record revealed he was admitted on . His 1823 Resident Health	A 025		

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 _____	07/23/2022

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 025	Continued From page 6 Assessment form, dated [redacted], indicated the resident was alert and oriented. His diagnoses included [redacted], and Resident #4's record revealed he was admitted on [redacted]. His 1823 Resident Health Assessment form, dated [redacted], indicated he was forgetful and [redacted] at times. His diagnoses included [redacted], and [redacted]. Resident #6's record revealed a facility admission date of [redacted]. An 1823 Health Assessment form, dated [redacted], indicated the resident's diagnoses included unspecified [redacted], and [redacted]. The resident was alert and oriented to person, place, time. Resident #7's record revealed a facility admission date of [redacted]. An 1823 Health Assessment form, dated [redacted], indicated the resident's diagnoses included [redacted], and [redacted]. The resident was alert and oriented. Resident #12's record revealed a facility admission date of [redacted]. An 1823 Health Assessment form, dated [redacted], indicated the resident's diagnoses included [redacted], and [redacted]. The resident was alert and oriented to person, place, time, and event, was guarded, loud, and hyperverbal. Review of the facility's "Emergency Environmental Control Plan", approved by the	A 025		

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 _____	07/23/2022

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 025	Continued From page 7 local Office of Emergency Management on , indicated in the event of a power outage, the facility's alternate power source would be used to cool common areas, offices, and hallways. Review of an email, sent by the Administrator to the Agency for Health Care Administration's (AHCA) field office on ..... at 4:22 PM, revealed the facility's plan was to conduct hourly wellness checks on those residents who refused to temporarily move to another room, or another facility, and water would be encouraged to the residents. The facility indicated they would ensure the room doors were open with fans positioned at the door to pull cool air from the hallways. The staff would let Administration know if any residents changed their mind about moving. Four portable A/Cs would be placed in the second-floor hallway. On , four residents, #3, #10, #11 and #12, were temporarily moved to a room within the facility where the A/C was working properly. Resident #13 temporarily went home with family. Eight residents, #1, #2, #4, #5, #6, #7, #8 and #9, remained in their rooms. On ..... at 9:15 AM, three portable A/C units were seen in the second-floor hallway. Each unit's heat exhaust vent was placed through an opening in the ceiling. On at 9:24 AM, resident #6 said she was comfortable in her room, and did not feel sick or have any other health related complaints. Her room temperature was checked using a Hygro-Thermometer. It indicated the air temperature was 83.6°F. The resident said she did not want to move temporarily to another	A 025		

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 _____	07/23/2022

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 025	Continued From page 8 facility, then said, "It's . . in here now." She said the facility's staff checked on her and provided her with hydration. Two box fans were seen in her room. On at 9:26 AM, resident #5 sat in a chair in the hallway outside his room. A floor fan was in his room doorway and was pointed towards the hallway. The resident said that most times he sat in the hallway, so staff were able to frequently monitor him and said he had water in his room. He said he did not have any health-related complaints and said he did not want to temporarily go to another facility. His room temperature was 84°F. On at 9:33 AM, resident #4 said it became too cool in his room overnight, so he turned off the box fan that was in his room. Air temperature was 74.3°F, checked with the Hygro-Thermometer. The resident said he did not have any health-related complaints. He said facility staff checked on him and provided him with liquids. On at 9:40 AM, resident #7 said his room was too hot. The room temperature, checked with the Hygro-Thermometer was 81.1°F. The resident said he did not have any health-related complaints. A small table fan and a floor fan were in his room. He said staff checked on him and offered him hydration. He said he agreed on the previous night to temporarily go to another facility but after it rained, his room cooled down, so he decided not to go. On . . . . . at 9:55 AM, resident #1 said it was too hot in his room. The room temperature, checked with the Hygro-Thermometer was 84°F. A box fan and a standard floor fan were in his	A 025		

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 _____	07/23/2022

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 025	Continued From page 9	A 025		

room. He denied any health-related complaints. He said staff did not check on him. A small refrigerator was in his room, which he said held drinks. He said the facility asked him to temporarily move to another facility or to another room within the facility, but he declined both options.

On ..... at 10 AM, an A/C repair technician was in the facility. He said the problem with the A/C unit was that someone put the wrong fan blade on, which eventually out the motor. He said he replaced both the blade and motor on that day and the unit was now working. He said a new A/C unit was purchased and would be installed on .

On at 10:30 AM, resident #8 denied any health-related complaints. He said he had a fan in his room and a -held fan. He said he had access to hydration.

On ..... at 10:35 AM, the Maintenance Supervisor brought four portable A/C units into the facility and placed one in a second floor television room.

On at 10:50 AM, resident #9 denied any health-related complaints. He said staff checked on him and that he had access to hydration.

On at 1:53 PM, a City Fire Inspector arrived at the facility and instructed the Maintenance Supervisor to remove the portable A/C heat exhaust vents from the hallway ceilings, which he did.

On at 2:45 PM, the facility's "Emergency Plan" was discussed with the Administrator, who said she would speak again with the residents to

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 _____	07/23/2022

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 025	Continued From page 10 discuss either moving to another facility or temporarily moving to a cooled common area within the facility. On [redacted] at 4:56 PM, the facility's owner was in the facility and said that he first learned about the air conditioning not working properly on either [redacted] or [redacted]. He stated it the Administrator made all the necessary calls to A/C repair companies and was responsible to manage the situation. The Administrator said she did not know she had to notify the licensing agency, AHCA, when the air-conditioning stopped working. When asked to provide documentation of the hourly wellness checks, that she indicated would be done in her email to AHCA on [redacted], the Administrator said the checks were not documented but she would ensure they were moving forward. The Administrator said [redacted] air temperatures were not checked in the affected resident rooms prior to the facility's purchase of a [redacted]-held [redacted] thermometer on [redacted], but rather she relied solely on resident interview responses on how they felt about the room temperature. On [redacted] at 5:15 PM, the Administrator said the facility's plan was to place a portable A/C unit in the rooms of residents #2, #3, #4, #5, #7, #9, #10, #11 and #12. Residents #1 and #8 would temporarily move to another room within the facility. Resident #6 would be temporarily moved to another facility. On [redacted] at 12 PM, the A/C repair technician was present at the facility and said two new A/C units were installed that morning. On [redacted] at 1:55 PM, the temperatures were checked with the Hygro-Thermometer in resident	A 025		

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 _____	07/23/2022

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 025	Continued From page 11 rooms and revealed the following: Resident #1's room temperature was 78.8°F Residents #2 and #10's room were 76.4°F Resident #7's room was 80.6°F Resident #9's room was 81.6°F Residents #4 and #11's room were 78.8°F On at 3:15 PM, resident #5's room was 72.8°F On at 3:30 PM, resident #9's room was 79°F On at 9 AM, the temperatures were checked with the Hygro-Thermometer in residents' rooms and revealed the following: Resident #7's room was 73°F Residents #4 and #11's room was 72.8°F Residents #2 and #10's room was 76°F Resident #5's room was 75°F Residents #6 and #13's room was 75°F Resident #1's room was 74°F Resident #9's room had a portable A/C unit, and the temperature was 67°F Residents #3 and #12's room was 74°F 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 meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A	A 077		

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 _____	07/23/2022

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 077	Continued From page 12 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 facility administrator must complete the required core training, including the competency test, within 90 days after the 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 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	A 077		

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 _____	07/23/2022

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 077	Continued From page 13 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 , 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 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 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	A 077		

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 _____	07/23/2022

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 077	Continued From page 14 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: Based on observations, interviews and record reviews, the facility's Administrator failed to oversee the operation and maintenance of the facility including the provision of appropriate care to 13 of 13 sampled residents when the facility did not monitor the general health, safety, and physical well-being of the residents whose room temperature exceeded 81 degrees Fahrenheit (°F) (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 & #13). Findings	A 077		

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 _____	07/23/2022

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 077	Continued From page 15 On during an investigation being conducted at the facility's sister facility it was discovered that the facility air conditioning was not functioning since ..... On ... at 9:08 AM during a facility tour, the second-floor common area felt warm. Three portable A/C units were set up in hallway with heat exhaust vents going through the ceiling tiles. On at 9:15 AM, the Administrator confirmed one of the A/C units was not working. She said ... , 26, 27, 28, 29, 32, 41, and 42 were affected by the A/C outage and felt warm. Staff had provided those residents with fans. On ..... at 9:45 AM, staff A said the facility had been working on the air conditioning last week. She said everyone has a fan in their room and staff asked them to keep their doors open so air can circulate. She said some of the residents still shut their doors. On at 9:53 AM, resident #4 said his room felt very warm. No box fan was observed in the room. The resident said the air had been out for about a week. He said he feels fine and has not been ill. At 9:58 AM, the Administrator provided a box fan for resident #4. On ..... at 10 AM, resident #5 was seated just outside his room and said his room was hot. He said he was feeling fine. A fan was observed in the doorway facing out. He said he was trying to blow the hot air out. On at 10:15 AM, the Administrator and the Maintenance Director confirmed they did not	A 077		

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 _____	07/23/2022

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 077	Continued From page 16 have a thermometer in the building to check the air temperature in rooms where residents were affected by the non-functioning A/C, but they would go buy one. On at 1:20 PM, with a held thermometer they had just purchased, the Administrator had the tempertures of the affected rooms taken: Temperature in hallway outside of was 87.4°F Inside , resident #1 room, temp was 88.5°F Hallway outside was 82.5°F Temperature in Resident #5 was 86°F Temperature in resident #6 was 87°F Temperature in resident #2 was 85.4°F Temperature in resident #11 was 84.7°F Temperature in resident #7 was 86°F Temperature in resident #8 was 88.5°F Temperature in resident #12 was 86°F On at 2:40 PM, staff D said he was aware of the air conditioning being out. He said it has been out since last week. He said he has been doing hourly checks on the residents and asking them to leave their doors open to circulate the air. He said he did not documented rounds. He said all the residents were okay with no distress or illness. On at 3 PM, staff E said she had been doing hourly checks on the residents since the air went out last week. She said she did not document the checks. She said she offered water and some of them wanted their cups filled. She said none of the residents were ill or complaining of feeling bad. Review of an email sent by the Administrator to	A 077		

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 _____	07/23/2022

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 077	Continued From page 17	A 077		

the Agency for Health Care Administration's (AHCA) field office on at 4:22 PM revealed the plan was to conduct hourly wellness checks on those residents who refused to temporarily move to another room, or another facility and water would be encouraged. The facility would ensure the room doors were open with fans positioned at the door to pull cool air from the hallways. The staff would determine whether any residents changed their mind about moving. Four portable air conditioners (A/C) would be placed in the second-floor hallway.

On , residents #3, #10, #11, and #12 were temporarily moved to a room within the facility where the A/C was working properly. Resident #13 temporarily went home with family. Residents #1, #2, #4, #5, #6, #7, #8, and #9 remained in their rooms.

On at 9:15 AM, three portable A/C units were seen in the second-floor hallway. Each unit's heat exhaust vent was placed through a hole in the hallway ceiling.

On at 10 AM, an A/C repair technician was seen in the facility. He said the problem with the A/C was that someone put the wrong fan blade on, which eventually burnt out the motor. He said he replaced both the blade and motor on that day and the unit was now working. He said a new A/C unit was purchased and once a crane was secured, the new unit would be installed, which he believed would happen on .

On at 10:35 AM, the maintenance supervisor was seen bringing four portable A/C units into the facility and was later seen placing one in a common second floor T.V. room. The unit's heat exhaust vent was placed through a

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 _____	07/23/2022

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 077	Continued From page 18 hole in the ceiling as well. On [redacted] at 1:53 PM, a City Fire Inspector arrived at the facility and instructed the Maintenance Supervisor to remove the heat exhaust vents from the hallway ceilings. The inspector also instructed the Maintenance Director to replace those ceiling tiles that holes were cut into to allow placement of the vents. Review of the facility's "Emergency Environmental Control Plan", which was approved by the local Office of Emergency Management on [redacted], indicated that in the event of a power outage, the facility's alternate power source would be used to cool common areas, offices, and hallways. On [redacted] at 2:45 PM, the plan was discussed with the Administrator, who said she would speak again with those residents who were in a room without a functioning A/C regarding whether they would agree to a temporarily move to another facility or be moved to a cooled common area within the facility. On [redacted] at 4:56 PM, the facility's Owner was present in the facility and said that he first learned about the A/C not working properly on either [redacted] or [redacted], and said it was the Administrator who made all of the necessary calls to A/C repair companies and who managed the situation. The Administrator said she did not know that she had to notify the licensing agency, AHCA, when the A/C stopped working. When asked by the surveyor to provide documentation of the hourly wellness checks that she indicated would be done in her email to AHCA on [redacted], the Administrator said the checks were not documented but she would ensure they were	A 077		

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 _____	07/23/2022

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 077	Continued From page 19 moving forward. The Administrator said air temperatures were not checked in the affected resident rooms prior to the facility's purchase of a -held thermometer on but rather she relied solely on resident interview responses on how they felt. On at 5:15 P.M., the Administrator said the facility's plan was to place a portable A/C unit in the room of residents #2, #3, #4, #5, #7, #9, #10, #11, & #12. Residents #1 & #8 would temporarily move to another room within the facility. Resident #6 would be temporarily moved to another facility. On at 12 P.M., the A/C repair technician was present at the facility and said two new A/C units were installed on that morning. On at 1:55 P.M., the temperature was checked with a hygro-thermometer in resident rooms and revealed the following: Resident #1's room temperature was 78.8°F Residents #2 & #10's room was 76.4°F Resident #7's room was 80.6°F Resident #9's room was 81.6°F Residents #4 & #11's room was 78.8°F On at 3:15 P.M., resident #5's room was 72.8°F On at 3:30 P.M., resident #9's room was 79°F On at 9 A.M., the temperature was checked with a hygro-thermometer in resident's rooms and revealed the following: Resident #7's room was 73°F Residents #4 & #11's room was 72.8°F Residents #2 & #10's room was 76°F	A 077		

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 _____	07/23/2022

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 077	Continued From page 20 Resident #5's room was 75°F Residents #6 & #13's room was 75°F Resident #1's room was 74°F Resident #9's room had a portable A/C unit, and the temperature was 67°F Residents #3 & #12's room was 74°F The Administrator did not contact AHCA at the onsite on the facility not having air conditioning. The facility was without air conditioning and was not able to cool the facility specifically the rooms for 13 residents who lived on the second floor. The Comprehensive Emergency Management Plan was not fully activated until . There was no documented evidence of monitoring and temperatures being taken of the affected area until , when the AHCA representative arrived at the facility. Class I	A 077		