Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965667	A. BUILDING: _____ B. WING _____	03/13/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Change of Ownership (CHOW), Complaint (2024002130, 2024005664, 2024006055, 2024015771, 2024015775, 2024015836, 2025000071 & 2025000652) and a Generator Monitoring survey was conducted on - at Arbor Oaks at Greenacres Assisted Living. The facility had deficiencies identified related to the CHOW and Complaint (2024015771, 2024015775 & 2024015836) at the time of survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c),	A 032		

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A 032	Continued From page 1 F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that daily supervision/observation of Residents took place	A 032		

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A 032	Continued From page 2 to ensure they were knowledgeable of resident(s) whereabouts for one (1) of (1) resident reviewed (Resident #13). And provide a safe and secure environment to prevent elopements. The findings include: A review of the facility's undated Elopement Policy Synopsis documented when a resident has been identified or observed as a risk for ␣ and/or elopement. Every effort is made to prevent and track ␣ residents while maintaining the least restrictive environment for those who are at risk for elopement. Elopement is defined when a resident leaves the facility property beyond the perimeter of the parking lot or further, without the facility knowledge, and who has not verbally informed the facility of their plans for returning to the facility. Inform staff of an at-risk resident upon admit and ensure proper intervention takes place. A Confidential report to the Agency dated 11:16:42 AM documented that on at approximately 7:00 PM the Resident left the secured (Memory Care) section of the facility. Specifically; it documented that at approximately 7:00 PM. It was noted that that was the last time resident (Resident #13) was seen by staff. The administrator was notified at 8:59 PM that the Sheriff had resident at the (local gas station) 0.8 miles from the community). It also documented: Resident eloped from secured area. (Administrator) received a call at 8:59 PM that the resident escaped facility and is with Officer at the gas station. The facility was	A 032		

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A 032	Continued From page 3 also notified by officer that he had resident. DON (Director of Nursing) was notified by (Administrator, Staff A) who then met officer and resident at the gas station (Name of station). Resident was sent to (Local hospital) for medical clearance for . Resident then sent to (Behavioral Health Care facility). It further documented; After review it was found that resident took wheelchair out rear door and used it to climb the fence. She was taken to the mobile station that is .2 miles from facility. On at 10:44 AM, observation was made by this surveyor of the exit door located in the Northeast section of the Memory Care Unit, which revealed the glass inside the door was broken out and wood placed in its place to secure it. The door leads to the outside fenced in area/courtyard (photo obtained). The window to the right of the door located at the end of the East hallway was observed to be unsecured. This surveyor lifted the window, and it opened. There were no alarm sensors or that signaled it was open. As such, a resident lifting the window can exit through it without being noticed (photo obtained). Observation on at 11:02 AM revealed the door on the white vinyl fencing located on the North section of the fencing was observed to be slightly open and unsecured. This surveyor pushed the door, and it opened to the outside. Observation of the outside of the door revealed a metal bar was screwed to it in order to secure it. The screws had been ripped from the plastic, leading to the fence door securing the being unsecured, allowing free access to outside (photo obtained).	A 032		

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A 032	Continued From page 4 As the facility has not taken corrective actions to prevent further elopements through securing windows, doors and fencing, residents in the Memory Care Unit remain at risk of elopement. Class III	A 032		
A 036	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by:	A 036		

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A 036	Continued From page 5 Based on observation and interviews, it was determined that, the facility failed to ensure staff implemented Control Procedures when assisting with Self-Administration of medication during a Medication Pass (Med Pass) for 2 out of 2 sample residents (Resident #30 and 31) The findings included: 1) An observation during a Medication Pass on in the Assisted Living on the first floor, outside the nurse's station at approximately 8:00 AM. This surveyor observed Staff J (Facility Nurse) putting the following medication into a medication cup for Resident #31; Cranberry Gummy 500MG, Tablet 5MG, Tablet 30MG, Tablet 10MG, Tablet 5MG, oral Tablet Disintegrating 5 MG, Slow Tablet 45MG, D3 Tablet 5000Unit, CO Q-10 Capsule 100MG and Tablet 500MG. Staff J used her bare and to remove the medication from the medication card (type of packaging that is used to hold and dispense medication) then dropped the medication into the medication cup. During an interview on at approximately 8:20 AM with Staff J, she acknowledged using her bare and to gather the medication from the card and dropping it into the medication cup. 2) An observation during a Medication Pass in the Memory Care Unit dining area on at approximately 9:00 AM, this surveyor observed Staff M (Medication Technician) putting the following medication into a medication cup for Resident #30; Tablet 6.25MG, Tablet 20MG, Tablet 25	A 036		

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A 036	Continued From page 6 MG, POT Tablet 20MEQ, Tablet 25MG, and Thera-M Tablet. Staff M used her bare and to remove the medication from the medication card then dropped the medication into the medication cup. During an interview on at approximately 9:10 AM with Staff M, she acknowledged using her bare and to gather the medication from the card and dropping it into the medication cup. During an interview on at approximately 6:30 PM with the Administrator and Staff F (Wellness Coordinator) they were both informed of the findings mentioned above. Class III	A 036		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer	A 056		

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A 056	Continued From page 7 medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of	A 056		

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A 056	Continued From page 8 medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed review the Medication Observation Record (MOR) and Medication Label at the time of a Medication Pass (Med Pass) for 3 out of 3 sample residents (Residents #23, 31 and 32) The findings included: Review of the facility's Policy and Procedures titled, Medication Information undated,	A 056		

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A 056	Continued From page 9 documented as follows: Medication Management To ensure all residents are assisted properly with their medication, the following procedures will be enforced: 8. All Staff assisting with medications will receive the required training. Assistance with Self-Administration of Medication Process 2. Right medication a. Check MEDICATION label and order three times. Check MOR, check LABEL, then check MOR with LABEL. 3. Check Dosage a. Triple Check the label with the MOR. 4.Right Time a. Check the TIME. Medications must be given at the TIME prescribed. Standard practice is that medications are given the TIME noted on the MOR or medication label. b. It is considered a medication error if outside the one-hour range. Best practice would be TIME exactly as indicated on MOR or prescription label. 8. Right Reason a. Confirm the rationale for the ordered medication. Why is he/she taking this medication? b. Revisit the reasons. If you are unsure of the reason for use, ask! Ask your pharmacist, doctor, or nurse. 10. Best Practices a. If you are not sure about the medication issue (i.e., drug to be given, dose, time, route, reason for taking medication) then ASK HCP, Nurse, or	A 056		

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A 056	Continued From page 10 pharmacist. B. Medication can help to improve and maintain health if taken and/or administered safely and appropriately. 1) An observation during a Medication Pass on in the Assisted Living on the first floor (outside the nurse's station) at approximately 8:00 AM, this surveyor observed Staff J (Facility Nurse) assisting Resident #31 with self-administration of medication. Record review of the facility's MOR dated documented the following medication for Resident #31. SOLOW Tablet 45 milligrams (MG), 8:00 AM Instructions: take one tablet by daily take with C. Further review revealed MOR and Medication Label have the same instructions. During an interview on at approximately 8:20 AM with Staff J, she stated that she was not aware of the medication instructions. She was asked if C for Resident #31 was available in the cart. Staff J stated that she was not sure. 2) An observation during a Medication Pass on in the Assisted Living at approximately 9:20 AM, the surveyor observed Staff E (Facility Nurse) assisting Resident #23 with self- administration of medication. Record review of the facility's MOR dated documented medication for Resident #23. Oral tablet 1000 MCG, 9:00 AM Instructions: take one tablet by once a week Start date:	A 056		

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A 056	Continued From page 11 Further review of the MOR documented Resident #23 received her medication everyday from through . During an interview on at approximately 9:50 AM with Staff E, was asked to provide a Physician order to reflect change from taking one tablet by once a week to every day as it was documented on the facility's MOR. Staff E stated that she would look for it. 3) An observation during a Medication Pass on in the Assisted Living on the second floor, common area at approximately 9:40 AM, this surveyor observed Staff J (Facility Nurse) assisting Resident #32 with self-administration of medication. Record review of the facility's MOR dated documented medication for Resident #32. , Capsule 20MG, 9:00AM Instructions: take one capsule by daily 30 minutes before breakfast. Further review revealed MOR and Medication Label have the same instructions. During an interview on at 9:43 AM with Resident #32, she was asked if she had breakfast, she stated yes. During an interview on at approximately 9:45 AM with Staff J, she was asked why Resident #32 was given her medication after she had breakfast. Staff J stated that she was not aware of the medication parameters (direction of use). During an interview on at approximately 6:30 PM with the Administrator and Staff F(Wellness Coordinator) they were both	A 056		

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A 056	Continued From page 12 informed of the findings mentioned above. No additional documentation was provided during the survey. Class III	A 056		
A 079	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times	A 079		

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A 079	Continued From page 13 when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or	A 079		

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	AL11965667	A. BUILDING: _____ B. WING _____	03/13/2025

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A 079	Continued From page 14 manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require	A 079		

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A 079	Continued From page 15 additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure they established/or maintained the required weekly direct care staff hours as required to provide care and services to 82 of 82 residents (Residents) in the facility.	A 079		

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A 079	Continued From page 16 The findings include: A review of the facility's undated Resident Care Aide Job Description documented the following: Performs assigned duties that protect the safety and dignity of residents. A resident Care Aide will work together with the Resident Care Supervisor and Assistant Administrator to ensure that resident care goals are being met, including providing care services, assistance, support and supervision to all residents. During observations of the breakfast and lunch dining at the facility on and the surveyor observed only one staff member in the main dining room serving breakfast. Specifically, observations of the breakfast dining on and /205 between 9: 00 AM and 9:45 AM only one (1) staff member was observed assisting with the breakfast for approximately 15-20 residents. In an interview with the Food Services Direct (Chef), Staff L on at 9:30 AM the surveyor asked him to confirm how many how many staff members were assisting with serving residents breakfast, and he stated there was only one staff member. As a result, residents were observed waiting their meals well beyond the established dining times (8:00 AM - 9:00 AM Breakfast and 12:00 Noon - 1:00 PM Lunch). Observation of the breakfast dining in the Memory Care Unit (MCU) on at 8:45 AM the surveyor observed the facility's Chef arriving to the MCU without the hotbox used to transport the meals from the kitchen to the MCU. In an interview with Staff L during the observation on at 8:50 AM, the surveyor asked why breakfast was not being served and he	A 079		

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A 079	Continued From page 17	A 079		

stated he was waiting for other staff to come and assist with serving the meal.

In an interview with the Administrator, Staff A on at 1:53 PM this surveyor asked for clarification regarding the Staff Schedule. Specifically, what staff worked in the AL and what staff listed worked in the MCU. This surveyor asked to clarify from the schedule how many people were scheduled to work, and where (AL or MCU) as the schedule provided did not specify. She was unable to clarify, and stated she would have the Wellness Coordinator, Staff F, to explain.

In an interview with Staff F on at 1:54 PM she stated the schedule provided repeats each week and it only changes if someone calls-out or leaves. She stated it is done that way because the staff is used to it, and they get if they change the format of the schedule. As per her, the schedule provided to the surveyors reflects the weekly staffing (copy obtained).

A review of the facility's Staff Schedule provided to the surveyors on revealed the facility provides 458 hours of direct care staff hours per week for a Resident Census of eighty-two (82) residents: Specifically, the Staff Schedule revealed the following relative to the facility's direct care staff levels:

Monday - Friday:

7:00 AM - 3:00 PM Shift: 2 Home Health Aides (HHA) in the Assisted Living and 1 Caregiver in the Memory Care Unit. The MCU Caregiver also assists in the AL.

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A 079	Continued From page 18 3:00 PM - 11:00 PM Shift: 2 Resident Care Aides in the Assisted Living and 1 Resident Care Aide in the Memory Care Unit. One AL Caregivers also assists in the MCU. 11:00 PM - 7:00 AM Shift - 1 Resident Care Aide in the Assisted Living and 1 Resident Care Aide in the Memory Care Unit. Saturday - Sunday: 7:00 AM - 3:00 PM -2 Resident Care Aides in the Assisted Living (AL) and 1 Resident Care Aide in the Memory Care Unit (MCU). The MCU Caregiver also assists in the AL. 3:00 PM - 11:00 PM - 2 Resident Care Aides in the Assisted Living and 1 Resident Care Aide in the Memory Care Unit. One AL Resident Care Aide also assists in the MCU. 11:00 PM - 7:00 AM - 1 Resident Care Aide in the AL and 1 Resident Care Aide in the Memory Care Unit The total combined hours (Assisted Living and Memory Care Unit) were as follows: 7:00 AM - 3:00 PM - 24 hours x 7 days/week = 168 hours 3:00 PM - 11:00 PM - 24 hours x 5 days/week = 168 hours 11:00 PM - 7:00 AM - 16 hours x 7 days/week = 112 hours Total direct care staff hours is 448 hours/week. In an interview with family members of Resident #33, on at 12:33 PM they stated they visit often and there is not enough staff, the	A 079		

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A 079	Continued From page 19 Resident is always in her wheelchair bent over, and they are afraid she's going to headfirst out of it. In an interview with the Private Duty Aide (PDA) for Resident #10 on at 12:43 PM she stated she has been coming to the facility for three (3) years, and they only have one staff all the time to take care of 24 people in the Memory Care Unit (MCU). She stated the facility only had this many people here today (3) because the surveyors were there. She stated she has to everything for the resident, and that when she comes in in the morning, she has to get him up because they have done nothing. In an interview with Resident #22 on at 9:35 AM, she stated to the surveyor that there is a Lack of staff to take care of the residents. In an interview with Resident #25 on at 10:10 AM, she stated to the surveyor that there is not enough help, and that sometimes no one comes when you alert them that you are in need of assistance. And because of there not being enough staff, the residents suffer. In an interview with Staff M, Resident Care Aide on at 1:15 PM, she stated to the surveyor that she works in the Memory Care Unit (MCU) at least 3 time a week, and that the facility has not hired enough staff to assist with the Residents. In an interview with Staff P, Resident Care Aide on at 1:28 PM, she stated to the surveyor she has been working at the facility for 2 months in both the Assisted Living and Memory Care Unit and that the facility needs to hire more staff.	A 079		

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A 079	Continued From page 20 In an interview with Staff N, MedTech on at 4:12 PM, she stated to the surveyor that they did not have enough staff and that they needed more people to assist with attending to the Residents. In an interview with Staff O, Resident Care Aide on at 5:00 PM, she stated to the surveyor that they did not have enough staff and needed additional staff. The facility had a Resident Census of 82 Residents during the survey on and , requiring a minimum of 458 hours of direct care staff hours per week. The facility provides 448 hours of direct care staff hours per week. As the facility has a Wellness Coordinator, Licensed Practical Nurse (LPN), and an Administrator who is CORE trained, their combined weekly hours when added would meet the weekly required hours. However, no documentation or information was provided relative to them providing ongoing -on care and services to residents in the same manner as the direct care staff. In an interview with the Administrator and Wellness Coordinator on at 4:57 PM, they were informed of the weekly direct care staffing hours, and that they did not meet the requirements. They acknowledged the findings. Class III Based on record review, observations and interviews, it was determined that the facility failed to provide sufficient staffing to meet the needs of the residents during mealtimes. This	A 079		

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A 079	Continued From page 21 has the potential to affect 82 residents (census at the time of the survey). The findings included: Review of the facility's Policy and Procedures titled, Grievance Policy and Procedure undated, documented as follows: Purpose: To ensure that all residents/family grievances are resolved in a timely and appropriate manner. Policy: 2. Grievances are to be resolved within five business days from the day of the grievance. a. individuals responsible for implementing the grievance and procedure are as follows: Administrator The following concerns were identified during the survey, that demonstrated the facility does not have enough staff scheduled during mealtimes to assist residents residing at the facility that potentially need assistance in the Assisted Living (AL) and Memory Care Unit (MCU) with food supervision such as assistance with feeding. Observations during a facility survey from - between 7:30 AM and 6:00 PM. On the surveyors observed only one staff member in the main dining room (first floor) serving residents' breakfast between 9:00 AM and 9:45 AM. During an interview on at approximately 9:30 AM this surveyor asked Staff L (Food Service Director) to confirm how many staff members were on the floor serving resident's breakfast. Staff L stated that there was	A 079		

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A 079	Continued From page 22 only one staff member. Further observation by the surveyors revealed approximately 15 residents in the dining room. An observation on at approximately 8:45 AM in the MCU, Staff L was observed arriving with a hot box on wheels containing breakfast for the MCU residents. During an interview at approximately 8:50 AM Staff L was asked why breakfast was not being served and he stated he was waiting for other staff members to assist with serving and to assist with residents that required assistance with feeding. An observation on at approximately 9:05 AM, this surveyor observed Staff G (Accounts Payable Coordinator), Staff H (Housekeeping) and Staff F (Wellness Coordinator) that were called to assist with breakfast. Staff H was setting up the tables, Staff G was distributing meals and Staff F was assisting the residents who are not able to feed themselves. During confidential interviews on and between 7:30 AM and 6:00 PM with the residents, it was revealed that the facility does not have enough staff to attend during mealtimes. Residents stated they have voiced their concern in their monthly meetings, regarding waiting time (waiting up to 20 minutes for a server to take their order) furthermore it was revealed that the facility Administrator and Staff L were aware of their concerns during their council meetings. During a confidential interview on at approximately 10:00 AM with a family member, it was revealed that their loved one has voiced her	A 079		

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A 079	Continued From page 23 concern regarding not enough servers on the dining room during mealtimes. During an interview on at approximately 6:30 PM with the Administrator and Staff F (Wellness Coordinator) they both acknowledged the findings. Class III	A 079		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested.	A 152		

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A 152	Continued From page 24 (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to establish and/or maintain a safe, clean and decent living environment free of hazards for 6 of 6 Residents (Residents 6,7,8,10,11,12) reviewed, interviewed, or observed. The findings include: On at 9:59 AM, an observation of the Memory Care Unit (MCU) by this surveyor revealed the floor in the dining room area was unclean and sticky, as evidenced by this surveyors' sticking to the floor while walking on it. at 10:44 AM, an observation was made of the exit door located in the Northeast section of the MCU, which revealed the glass inside the door was broken out and wood placed in its place to secure it. The door leads to the outside fenced in area/courtyard (photo obtained). The window to the right of the door located at the end of the East hallway was observed to be unsecured. This surveyor lifted the window, and it opened. There were no alarm sensors or that	A 152		

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A 152	Continued From page 25 signaled it was open. As such, a resident lifting the window can exit through it without being noticed (phot obtained). Observation 0n at 11:02 AM revealed the door on the white vinyl fencing located on the North section of the fencing was observed to be slightly open and unsecured. This surveyor pushed the door, and it opened to the outside. Observation of the outside of the door revealed a metal bar was screwed to it in order to secure it. The screws had been ripped from the plastic, leading to the fence door securing the being unsecured, allowing free access to outside (photo obtained). In an interview with a family member of Resident #14 on at 12:33 PM, they stated that whenever they visit the facility, the resident's room always has a foul order indicating it isn't cleaned or cleaned properly. Observation by this surveyor on at 12:23 PM of the hallway by . revealed a strong smell, which was also observed during the visit to the MCU by this surveyor on . Class III	A 152		

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CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

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

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965667	A. BUILDING: _____ B. WING _____	03/13/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	CZ830		

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure its Comprehensive Emergency Management Plan (CEMP) was submitted and approved by the Local County Emergency Management Division following a change of ownership. The findings included: During an interview with the Administrator on at approximately 9:30 AM she was informed to provide the facility's current CEMP approval letter or proof of communications and submissions to the Local County Emergency Management Division. The Administrator stated that the facility had a change of ownership in . This surveyor made a request to the Administrator to provide the last CEMP submission to the Local County Emergency Management Division. During the survey on through , the Administrator provided the Surveyors with a binder containing their Comprehensive Emergency Management Plan (CEMP). Further review revealed the facility did not have any documentation in file of the last CEMP approval status. During an interview with the Administrator on at approximately 6:30 PM she was informed of the findings mentioned above. No additional documentation was provided.	CZ830		

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CZ830	Continued From page 3 Class III	CZ830		