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
	AL11967749	A. BUILDING: _____ B. WING _____	R 06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE ASSISTED LIVING FACILITY	4301 31ST ST SOUTH SAINT PETERSBURG, FL 33712

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{A 000}	Initial Comments A revisit to complaint investigation (complaint numbers: 2021006201 and 2021006688), a re-licensure biennial survey, a complaint investigation (complaint numbers: 2021004473 and 2021006387), a COVID-19 focused control visit, and a generator monitoring and were conducted at Angel Care Assisted Living Facility on . Deficiencies were identified at the time of survey.	{A 000}		
{A 055} SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of	{A 055}		

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physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or
6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C.
(c) Centrally stored medications must be:
1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and,
4. Kept separately from the medications of other residents and properly closed or sealed.
(d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider.
(e) When a resident's stay in the facility has

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{A 055}	Continued From page 2	{A 055}		

ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f).
(f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
(g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on observation and interview, the Facility failed to keep centrally stored medication in a locked cabinet or cart and secured at all times.

Findings included:

During observations, conducted on [redacted], revealed the following:

-At 05:02am, Resident #18's prescribed [redacted], 40mg pill pack was lying openly on a shelf at the South Hall's medication station. There were twenty-three pills in the pill pack. The door to a small storage room behind the medication station was wide open. In the storage room was a mini refrigerator that was not locked and inside the refrigerator were fourteen boxes of medications and one bottle of medicated [redacted]

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{A 055}	Continued From page 3 drops. The medications were stored with an opened beverage can. The refrigerator had food and beverage spills. There was no staff present in or around the medication station. -At 06:41, there was a bag of Resident #17's [redacted] medication lying on the South Hall's medication station counter. There was no staff present in or around the medication station. -At 07:10am, a box of Resident #17's Invega Sustenna 117mg [redacted] injectable medication was lying on the windowsill in the Administrator's office. The Administrator's office was left unlocked and without staff present at 07:30am, 11:15am, and 01:43pm. During an interview with the Administrator, conducted on [redacted] at 10:20am, the Administrator agreed that medications were to be kept locked/secured at all times. Class III	{A 055}		
A 058 SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ	A 058		

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A 058	Continued From page 4 the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant	A 058		

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A 058	Continued From page 5 visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to correct Class III deficiencies related to medications as required and had new medication deficiencies. Findings Included: During a revisit to complaint investigation, conducted on . . . . . , revealed that the Facility failed to correct Class III medication deficiencies. Due to the uncorrected Class III deficiencies concerning the facility's medication practices, the facility shall be required to employ the consultation services of a licensed pharmacist or a registered nurse. The consultant shall at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. This written statement serves as notification of the above stated requirement.	A 058		

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A 058	Continued From page 6 Class III	A 058		
{A 077} SS=G	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 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	{A 077}		

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{A 077}	Continued From page 7 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}		

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{A 077}	Continued From page 8	{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 9 Based on observation, record review, and interview, the Facility failed to be under the supervision of an Administrator that was responsible for the operation and maintenance of the facility and provided oversight to ensure that there was enough staffing to ensure that medications, meals, housekeeping, maintenance were provided as needed for scheduled and unscheduled needs. Findings Included: During observations, conducted on . . . . . , revealed that the Facility did not keep all centrally stored medications locked and secured at all times observed at 05:02am, 06:41am, 07:10am, 07:30am, 11:15am, and 01:43a. This included unsecured medications in the Administrator's office for Resident #17, at the South Hall medication stations, a mini refrigerator with . . medications, and Resident #18's medication. Food and beverages were stored with refrigerated medications. During a review of employee timecards, conducted on , revealed that the Facility did not have a Medication Technician present during the nighttime for residents scheduled and unscheduled medication needs on from 11:32pm to at 06:40am; on . . . . . from 11:08pm to at 06:46am; and, on . . from 01:14am to 06:25am. A review of Resident #20's Medication Observation Records, conducted on . , revealed that Resident #5 did not receive his 05:00am medications on , , ... , and	{A 077}		

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{A 077}	Continued From page 10 A review of the meal menus, conducted on , revealed that the Facility had not obtained an approved menu since and that the Registered Dietician's license on record was not valid. During observations, conducted on from 05:00am through 07:47am found many environmental concerns that included: -There was an electrical short in which the entire call light system was non-functional and there were no lights/electricity in . -The South Hall had standing water one the floor in which two towels and a large fan was placed. There was an oscillating fan at the medication station that was turned on and the fan had a massive accumulation of dust. - , 4, 5, 6, 7, and 8 in the Memory Care Unit had broken furniture, paint peeling from doors, and tattered, torn, and peeling up flooring. The window style air conditioning units had massive accumulations of dust to the inside air vents and bio growth to the outside air vents. -Bathrooms 1, 2, 3, 4, 5, 6, 7, and 8 in the Memory Care Unit were unclean bathrooms including sinks, bathtubs, showers, toilets, mirrors, floors, and soap dispensers with smears of unknown substances, dust, dirt, debris, and drips. There were broken or worn and discolored toilet seats, toilet paper holders, and shower heads. Two bathrooms had standing water from plumbing leaks. There were showers with corroded and/or rusted metal fixture to faucets and drains. During an observation, conducted on at 10:38am, it was observed that 's door	{A 077}		

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{A 077}	Continued From page 11 in the Memory Care Unit was wide open with no staff within sight of the room. This room had direct access out of the door onto and off the property. During a call light response test, conducted on at 07:00am, a call light was pulled. At 07:30am, no staff had answered the call light. During an attempt to review scheduled or services obtained for the standing water in the South Hall, conducted on , there was none provided. During interviews with residents conducted on revealed the following: -At 05:29am, Resident #3 stated that the cook does not show up and the kitchen is short-staffed and the water on the floor was leaking for about a week. -At 07:00am, Resident #5 sated that a couple of days ago that residents did not receive any breakfast. -At 07:32am, Resident #4 stated that she tried to use the call light and it did not work. At 10:47am, Resident #4 stated that sometimes the Facility did not have a cook and does not receive breakfast until 10:00am. -At 07:36am, Resident #21 stated that the lights had been out since yesterday in . -At 10:00am, Resident #13 stated that the staff take a long time answering the call light. -At 10:25am, Resident #12 stated that the staff take a long time answering the call light.	{A 077}		

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{A 077}	Continued From page 12 -At 10:30am, Resident #8 stated that staff do not answer the call lights. During an interview with Staff D, conducted on at 06:56am, Staff D stated that she was the only staff on duty to assist with fifty-five residents' medications, care needs, problems, issues/concerns, . . and whatever and it gets overwhelming. At 07:35am, Staff D stated that the water was leaking from the walls. Staff D stated that there was a short in the call light system. During a tour with the Owner, conducted on . . . . . at 10:38am, the Owner agreed that 's door being wide open with no staff present presented easy access to exit the Facility for those residents residing in memory care who were at risk for elopement and was a safety hazard. The Owner observed all the aforementioned findings to the environment concerns and that the Facility was not clean to the bathroom floors, baseboards, toilets, bathtubs, showers, mirrors, and soap dispensers. The Owner stated that he would not use the toilet in 's bathroom. The Owner agreed that the corroded and/or rusted and broken bathroom fixtures were unsightly and in need of repair or replacement and presented a safety hazard to both staff and residents. The Owner agreed that the tattered, torn, and peeling up flooring was unsightly, unsafe, and not homelike. The Owner agreed that the accumulation of dust and bio growth were a health hazard to residents and staff. The Owner agreed that the dining table bases needed to be cleaned. During an interview with the Administrator, conducted on at 07:30am, the Administrator stated that Medication Technicians	{A 077}		

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{A 077}	Continued From page 13 needed to focus on the medication pass while passing medications. The Administrator was unable to explain how one staff person could tend to medications, care needs, and unexpected issues for fifty-five residents and stated that the medication was not that heavy in the morning. At 11:39am, the Administrator stated that on the chef did not show up and resident did not receive breakfast until 10:00am. At 01:45pm the Administrator stated that Resident #20 had scheduled medications at 05:00am and that it was possible that Med Tech's were giving the medication late and once the oncoming Med Tech clocks on duty. The Administrator agreed that the window for giving medication was one hour before and one hour after the scheduled time. At 11:26am with the Administrator she stated she did not have an updated menu or updated copy of the Registered Dietician's license. At 02:10pm, the Administrator was unable to provide any documents of services obtained to repair the water leaks. The Administrator stated that she would call the company to check out the call light system. Class II	{A 077}		
{A 079} SS=G	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	{A 079}		

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{A 079}	Continued From page 14	{A 079}		

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 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 [illegible] ( ) 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

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{A 079}	Continued From page 15 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 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.	{A 079}		

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{A 079}	Continued From page 16 (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 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	{A 079}		

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{A 079}	Continued From page 17 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 observation, record review, and interview, the Facility failed to provide adequate staffing to meet the scheduled and unscheduled needs of residents. Findings included: During observations of the medication pass with Staff D, conducted on from 05:30am through 06:56am, it was observed that residents were frequently interrupting Staff D while she was passing medications with various care needs such as issues with meals and food service, water not being passed, complaints about smoke breaks, and assistance with activities of daily living. During an interview with Staff D, conducted on at 06:56am, Staff D stated that she was the only staff on duty to assist with fifty-five residents' medications, care needs, problems, issues/concerns, and it gets overwhelming.	{A 079}		

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{A 079}	Continued From page 18 During a review of employee timecards, conducted on , revealed that the Facility did not have a Medication Technician present during the nighttime for residents scheduled and unscheduled medication needs. -On , Staff F, a Medication Technician (Med Tech) , clocked off duty at 11:32pm and Staff G a Med Tech clocked on duty on at 06:40am. -On Staff H, a Med Tech, clocked off duty at 11:08pm and Staff G a Med Tech clocked on duty on at 06:46am. -On Staff F, a Med Tech, clocked out at 01:14am and Staff I a Med Tech clocked on duty at 06:25am. A review of Resident #20's Medication Observation Records, conducted on , revealed that Resident #5 had the prescribed medication , 15mg ordered to take one tablet every four hours. This medication was documented as not given on , , , and at 05:00am. During an interview with Resident #3, conducted on at 05:29am, Resident # 3 stated that the cook does not show up or they are short, and we just get cereal or grits. During an interview with Resident #4, conducted on at 10:47am, Resident #4 stated that sometimes we do not have a cook and do not get breakfast until 10:00am. During an interview with Resident #5, conducted on at 07:00am, Resident #5 stated a	{A 079}		

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{A 079}	Continued From page 19 couple of days ago we did not get breakfast. During an interview with the Administrator, conducted on at 07:30am, the Administrator stated that Med Techs needed to focus on the medication pass while passing medications. The Administrator was unable to explain how one staff person could tend to medications, care needs, and unexpected issues for fifty-five residents and stated that the medication was not that heavy in the morning. At 11:39am, the Administrator stated that on the chef did not show up and she had to prepare breakfast for the residents and breakfast was served to residents close to 10:00am. At 01:45pm the Administrator stated that Resident #20 had scheduled medications at 05:00am and that it was possible that Med Tech's were giving the medication late and once the oncoming Med Tech clocks on duty. The Administrator agreed that the window for giving medication was one hour before and one hour after the scheduled time. Class II	{A 079}		
{A 152} SS=D	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	{A 152}		

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{A 152}	Continued From page 20 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 [illegible] 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. (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 [illegible] This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interview, the Facility failed to provide a clean and decent living environment free from hazards. Furthermore, the Facility failed to maintain all existing mechanical and electrical systems in good working order. Findings Included: During observations in the Assisted Living Unit, conducted on , the following was	{A 152}		

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{A 152}	Continued From page 21 observed: -At 05:00am in the South Hallway in front of -33, there was a large fan blowing on the floor and two wet towels. There was standing water that was observed on the floor. -At 07:43am in the dining room, there were fourteen of fourteen table bases that were visibly dirty with dust, grime, food, and drink spills. -At 07:47am at the South Hall medication station desk, there was a fan blowing that had a massive accumulation of dust. During a call light response test, conducted on at 07:00am, a call light was pulled. At 07:30am, no staff had answered the call light. During observations in the Memory Care Unit, conducted on , the following was observed: -At 07:18am in , there was a broken dresser in which the drawers would not close all the way. The flooring was tattered and torn. The paint on the door to the bathroom was peeling off. The shower walls and floor were visible dirty with grime. The metal shower drain was rusted. The bathroom floor had not been swept and had visible dirt and debris in front of the shower and around behind the toilet and on the baseboards. There was no toilet paper in the bathroom throughout survey. -At 07:20am in , the shower mat was visibly dirty with bio growth noted. The shower was broken. The shower walls and floor were visibly dirty. The toilet was covered in	{A 152}		

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{A 152}	Continued From page 22	{A 152}		

dust/dirt and drips. The mirror was spotty and unclean. The room flooring was tattered, torn, and peeling up.

-At 07:23am in , the window style air condition (AC) unit's vents were dirty with a lot of dust accumulation. The paint was peeling from wall around the AC unit. The toilet paper holder in the bathroom was broken. The floor around the toilet was visibly dirty with dust and debris and not swept. The toilet was visible dirty with dust. The shower fixtures had a lot of corrosion. The tub was visibly stained and dirty. The bedroom floor was tattered, torn, and peeling up.

-At 07:25am in , the bedroom floor was tattered, torn, and peeling up. The bathroom floor was visibly dirty with smears of an unknown substance. The toilet seat was worn, stained, and broken. There was standing water around the bathtub from an unknown source and possible leak. The shower metal drain had a lot of corrosion. The bathtub was visibly dirty. The metal toilet paper holder was broken and corroded. There was bio growth noted to the AC units outside air vents.

-At 07:30am, in , the flooring was tattered, torn, and peeling up. The paint was cracked and peeling from the door. The metal toilet paper holder was broken and corroded. There was bio growth to the AC units outside air vents.

-At 07:32am, in , there was no lights/electricity that was functioning to this room and bathroom. The paint was peeling from the wall around the AC unit. The paint was cracked and peeling off of the entry door.

-At 07:34am in , the AC unit had massive

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{A 152}	Continued From page 23	{A 152}		

dust accumulation to the inside vent and bio growth to the outside vents. The bathroom's mirror was covered in spots all over from an unknow substance. The soap dispenser was visibly dirty/dusty. The toilet seat was worn and stained. The toilet paper holder was broken. the tub was visibly dirty and stained. The bathtub drain was rusted and corroded. There was standing water around the toilet from an unknown source and possible leak.

-At 07:36am in , there was no lights/electricity that was functioning to this room and bathroom. The AC units outside air vents were covered in bio growth. The flooring was tattered, torn, and peeling up.

During an interview with Resident #3, conducted on at 05:29am, Resident #3 stated that the water had been leaking on the floor for about a week.

During an interview with Resident #4, conducted on at 07:32am, Resident #4 stated that she has tried to use her call light, but it doesn't work.

During an interview with Resident #21, conducted on at 07:36am, Resident #21 stated that the lights had been out since yesterday in .

During an interview with Resident #13, conducted on /2201 at 10:00am, Resident #13 stated that the staff take a long time answering the call light.

During an interview with Resident #12, conducted on /2201 at 10:25am, Resident #12 stated that the staff take a long time answering the call

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{A 152}	Continued From page 24 light. During an interview with Resident #8, conducted on at 10:30am, Resident #8 stated that staff do not answer the call lights. During an interview with Staff D, conducted on 07:35am, Staff D stated that the water was leaking from the walls. Staff D stated that there was a short in the call light system. During a tour with the Owner, conducted on at 10:38am, it was observed that 's door in the Memory Care Unit was wide open with no staff within sight of the room. This room had direct access out of the door onto and off the property. The Owner agreed that this presented easy access to exit the Facility for those residents residing in memory care who were at risk for elopement and was a safety hazard. The Owner observed all the aforementioned findings to the Memory Care Unit and agreed that the Facility was not clean to the bathroom floors, baseboards, toilets, bathtubs, showers, mirrors, and soap dispensers. The Owner stated that he would not use the toilet in 's bathroom. The Owner agreed that the corroded and/or rusted and broken bathroom fixtures were unsightly and in need of repair or replacement and presented a safety hazard to both staff and residents. The Owner agreed that the tattered, torn, and peeling up flooring was unsightly, unsafe, and not homelike. The Owner agreed that the accumulation of dust and bio growth were a health hazard to residents and staff. The Owner agreed that the dining table bases needed to be cleaned. A review of the Residency Agreement/Contract, conducted on , revealed that the	{A 152}		

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{A 152}	Continued From page 25 Facility agreed to provide each unit/apartment with an emergency pull cord in the bedroom and bathroom to call for assistance. A review of the plumbing services invoice dated , conducted on , revealed that the plumbing service stated that they were at the Facility to repair toilet issues in three rooms but did note on the invoice that they "did see water in hallway possible slab leak". There was no evidence that the plumbing service investigated the standing water issue. During an attempt to review scheduled or services obtained for the standing water in the South Hall, conducted on , there was none provided. During an interview with the Administrator, conducted on at 02:10pm, the Administrator stated that the plumbers were here yesterday and said the water down the South Hall was a slab leak. The Administrator stated that she would call the company to check out the call light system. photographic evidence obtained Class III	{A 152}		