STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 000	Initial Comments An unannounced relicensure, emergency power plan, health facility reporting system, generator, visitation form, and complaint survey for #2022007373, #2023001940, #2023005430, #2023010698, and #2023015747 was conducted on [redacted] through [redacted] at Bayshore Memory Care, an assisted living facility in Naples, Florida. Complaint #2022007373 was substantiated at A 032. Complaint #2023001940 was substantiated at A 030. Complaint #2023005430 was substantiated at A 030 and A 032. Complaint #2023010698 was unsubstantiated. Complaint #2023015747 was unsubstantiated. The following is a description of the deficiencies.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The	A 008		

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

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THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 008	Continued From page 1 medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and	A 008		

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 008	Continued From page 2	A 008		

determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of [illegible] require such assistance.

59A-36.006
(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection.
(a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following:
1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,
2. An evaluation of whether the individual will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 008	Continued From page 3	A 008		

require supervision or assistance with the activities of daily living,
3. Any nursing or services required by the individual,
4. Any special diet required by the individual,
5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,
6. Whether the individual has signs or symptoms of , or any other communicable , which are likely to be transmitted to other residents or staff,
7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and,
8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner.
(b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed.
1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 008	Continued From page 4 and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (f) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not	A 008		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 008	Continued From page 5 exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure Health Assessments - Form (1823) of residents admitted to the facility are reviewed for accuracy for 2 (Resident # 1, # 15) of 3 resident records reviewed. The findings included: 1. Record review of the clinical record for Resident #1 revealed he was admitted to the facility on . Resident #1's clinical record contained documentation of a Health Assessment Forms (1823) signed and dated . The assessment was more than 60 days prior to admission to the facility. The Health Assessment section 2 Self-Care and General Oversight Assessment- Medications B. documents the resident needs medication Administration. On at 2:52 p.m., the Regional Health and Wellness Director stated Resident #1 was admitted to the facility in and his 1823 health assessment accepted by the facility was completed in . The Regional Health and Wellness Director confirmed the health assessment is out of compliance with the required time frame. On at 2:58 p.m., the Administrator stated the facility has unlicensed personnel (med techs) that assist with self-administration of medications on a daily basis. The Administrator said if the 1823 is marked a resident needs	A 008		

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 008	Continued From page 6	A 008		

medication administration, they would get clarification from the physician to determine if the resident needs assistance with self-administration or nurse required administration of medication. The Administrator confirmed Resident #1's 1823 is marked as needs administration of medications. She said this is not acceptable as they only have med techs to assist with medications. The Administrator said the 1823 is inaccurate regarding medication administration.

On at 3:06 p.m., the Regional Health and Wellness Director said for Resident #1, the facility should have done a proper assessment of the 1823, as the facility does not provide medication . The Regional Health and Wellness Director reviewed Resident #1's Health Assessments (1823) and confirmed medication administration is checked and should not have been checked; it is checked incorrectly. She stated the resident will have to have a new 1823 completed.

2. Record review of the clinical record for Resident #15 revealed he was admitted to the facility on . Resident #15's clinical record contained documentation of a Health Assessment Forms (1823) signed and dated . The Health Assessment section 2 Self-Care and General Oversight Assessment- Medications the options, 'Needs Assistance With Self-Administration' and 'Needs Medication Administration' are both checked.

On at 10:31 a.m., the Regional Health and Wellness Director said the Executive Director is the person responsible for reviewing 1823 health assessments upon a resident admission to the facility. The Regional Health and Wellness Director confirmed Resident #15's 1823 is

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 008	Continued From page 7 inaccurate as the staff would not know what help the resident needed with his medications as both boxes for med administration and assistance with self-administration are checked. She said the 1823 should have been redone. Class III	A 008		
A 009 SS=D	59A-36.006(3) FAC; 400.0078(2) Admissions - Admission Package (3) ADMISSION PACKAGE. (a) The facility must make available to potential residents a written statement(s) that includes the following information listed below. Providing a copy of the facility resident contract or facility brochure containing all the required information meets this requirement. 1. The facility's admission and continued residency criteria; 2. The daily, weekly or monthly charge to reside in the facility and the services, supplies, and accommodations provided by the facility for that rate; 3. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any; 4. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any; 5. Food service and the ability of the facility to accommodate special diets; 6. The availability of transportation and additional costs to the resident, if any; 7. Any other special services that are provided by the facility and additional cost if any; 8. Social and leisure activities generally offered by the facility;	A 009		

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 009	Continued From page 8	A 009		

9. Any services that the facility does not provide but will arrange for the resident and additional cost, if any;
10. The facility rules and regulations that residents must follow as described in Rule 59A-36.007, F.A.C.;
11. The facility policy concerning pursuant to Section 429.255, F.S., and Rule 59A-36.009, F.A.C., and Advance Directives pursuant to Chapter 765, F.S.;
12. If the facility is licensed to provide extended congregate care, the facility's residency criteria for residents receiving extended congregate care services. The facility must also provide a description of the additional personal, supportive, and nursing services provided by the facility including additional costs and any limitations on where extended congregate care residents may reside based on the policies and procedures described in Rule 59A-36.021, F.A.C.;
13. If the facility advertises that it provides special care for individuals with and related , a written description of those special services as required in Section 429.177, F.S.; and,
14. The facility's resident elopement response policies and procedures.
(b) Before or at the time of admission, the resident, or the resident's responsible party, guardian, or attorney-in-fact, if applicable, must be provided with the following:
1. A copy of the resident's contract that meets the requirements of Rule 59A-36.018, F.A.C.,
2. A copy of the facility statement described in paragraph (a) of this subsection, if one has not already been provided,
3. A copy of the resident's bill of rights as required by Rule 59A-36.007, F.A.C.; and,
4. A Long-Term Care Ombudsman Program

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 009	Continued From page 9	A 009		

brochure that includes the telephone number and address of the district office.
(c) Documents required by this subsection must be in English. If the resident is not able to read, or does not understand English and translated documents are not available, the facility must explain its policies to a family member or friend of the resident or another individual who can communicate the information to the resident.

400.0078
(2) Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding:
(a) The purpose of the State Long-Term Care Ombudsman Program.
(b) The statewide toll-free telephone number and e-mail address for receiving complaints.
(c) Information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right.
(d) Other relevant information regarding how to contact representatives of the State Long-Term Care Ombudsman Program.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the admission packet contained all required information.

The findings included:

A review of the admission packet revealed the following missing information per Florida Administrative Codes 59A-36.006 and 59A-36.007(d) 3, 4, and 59A-36.011(3)(a), (c), (f),:
1. Medication Storage procedure incomplete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 009	Continued From page 10 Exhibit Q, 2. Incomplete Elopement procedure - missing procedure to insure identification is on the resident daily and staff procedure for checking such, incomplete Exhibit Q, 3. Reporting Neglect and policy and procedure, incomplete Exhibit Q 4. Administration schedule, 5. Control, Sanitation, and Universal Precautions policy and procedure, incomplete Exhibit Q, 6. Assistive Devices policy and procedure, incomplete Exhibit Q, 7. Physical policy and procedure, incomplete Exhibit Q. 8. Exhibit Q Telephone Usage provides there will be access to a community phone to place and receive calls in private, yet does not provide a location in the assisted living or the memory care units. 9. Exhibit E Grievance Procedure was incomplete, as it included a time frame for step 7, but lacked time frames for steps . During an interview on at approximately 3:45 p.m., the administrator said the admission packet was complete and up-to-date.	A 009		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the	A 030		

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 030	Continued From page 11	A 030		

admission package provided pursuant to Rule 59A-36.006, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 030	Continued From page 12	A 030		

8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from . . . . . and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 030	Continued From page 13	A 030		

personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making

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
	AL11969737	A. BUILDING: ______ B. WING ______	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	**2219 CHIQUITA BLVD S** **CAPE CORAL, FL 33991**

(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 030	Continued From page 14 for health care services, the provision of or arrangement of transportation to health care , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.	A 030		

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 030	Continued From page 15	A 030		

(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 030	Continued From page 16	A 030		

facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.

This Statute or Rule is not met as evidenced by:
Based on record review, family and staff interview, the facility failed to ensure the right to live in a safe environment free from and neglect for 1 (Resident #13) of 3 residents reviewed for . The facility failed to ensure written notice of rights was posted in a prominent place in the facility which included the statewide toll-free telephone number, and email address of the local ombudsman, the elder hotline and if applicable, Rights Florida, where complaints may be lodged. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program. The facility failed to update the service plan after a with preventative precautions for 1(Resident #16) of 3 residents records reviewed.

The findings included:

A tour of the common areas of all three assisted living floors and the memory care unit revealed there were no posting of the statewide toll-free telephone number and email address, and no elder hotline or Rights Florida posting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 030	Continued From page 17 On at 10:00 a.m., The Admissions Coordinator verified the required information was not posted in either the ALF or memory care unit. She confirmed residents did not have access to make a private phone call in either the assisted living or memory care unit. Facility policy titled and Neglect Reporting, issued , stated experience senior living strives to provide a safe environment for all residents. The procedure included education of staff to recognize signs of and neglect at the time of hire, annually and as needed. 1. A review of the resident record revealed Resident #13 was admitted to the facility . Resident #13's diagnoses included unspecified without behaviors and . The 1823 dated noted the resident required total assistance with bathing, , grooming, and eating. On at approximately 3:00 a.m., facility Staff F reported to Staff Nurse L that she witnessed Staff G slap resident #13 in the causing her to to the ground. Staff F assisted Resident #13 and notified the nurse. On at 9:52 a.m., Caregiver/Medication Technician (Med Tech) Staff A said she completed on-line training for and neglect but did not attend any in person training. On at 10:12 a.m., Caregiver/Medication Technician (Med Tech) Staff B said she completed on-line , neglect, and reporting training, but did not have any facility specific training.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 030	Continued From page 18 On at 1:43 p.m., Resident #13's daughter said she was informed her mom had been slapped by a caregiver causing her to to the ground. The daughter said, "I had to take her to the emergency room because she hit her when she . My mom has and trouble sleeping but was not able to tell me what happened to her. She seemed to be getting more nervous but once the staff that hurt her were gone, it seemed like she was doing so much better. I had not envisioned anything bad happening to her there, I would visit every day". On at 6:49 a.m., Staff I said she completed her and neglect training upon hire on the computer. It was not specific to the facility. On at 7:00 a.m., Staff J said she had been employed on night shift for about 1 month. She completed on-line training for and neglect but did not have any facility specific training. On at 7:04 a.m., Staff K said she completed her training on the computer but did not have any training from administration or management. On , record review of the facility investigation revealed the facility nurse was made aware of Resident #13 being assaulted on and failed to report the allegation to the executive director. In a written statement, Staff F said Resident #13 was following Staff G out of her room when she saw Staff G turn around and slap Resident #13 in the causing her to to the floor. Staff F reported this to the nurse on duty.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 030	Continued From page 19 On at 3:15 p.m. the Executive Director (ED) confirmed all three staff working and involved in the incident were terminated. The ED said the nurse should have reported the alleged when the incident occurred. The ED confirmed the new employee orientation was done on the computer but was not facility specific. 2. Review of Resident #16's clinical record revealed she was admitted to the facility on . Further review revealed Resident #16 had a on which required a transfer to the hospital and was diagnosed with a . Resident #16 returned to the facility on . There was no documentation of an updated service plan with preventions for Resident #16 upon return to the facility. On at 1:08 p.m. in an interview, the Health and Wellness Director (HWD) stated she found no documentation of an updated service plan for the Resident #16 after her to indicate precautions were put in place to prevent further . Class III	A 030		
A 032 SS=E	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 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 032	Continued From page 20	A 032		

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), 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 032	Continued From page 21 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 interviews, record reviews, and observations, the facility failed to ensure the safety of the residents by following the elopement policy/procedures for 3 (Residents #11, #12 and #13) of 3 elopements reviewed. Further, failure to follow regulatory requirements found staff were not trained in the facility elopement policy and lacked elopement drill training. Facility failure to follow the policy allowed Resident #11 to walk multiple blocks away along a 4-lane thoroughfare and has the potential to lead to serious injury or [redacted] from elopements. The findings included: Requested and obtain a policy titled Resident [redacted] and Elopement. Date of issue: [redacted]. Last revised [redacted]. Last reviewed: [redacted] Under C: "The Director, Health & Wellness (DHW) or designee, will complete the Risk Scale in Point click Care prior to or within the first 24 hours of move in. D. After the evaluation is complete, the Director, Health & Wellness will complete an individualized	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 032	Continued From page 22	A 032		

service plan appropriate for the resident. . .
2. Assess and identify potential areas throughout the community; (i.e. stairwells, exit doors, lobby doors, storage areas, basements, etc.) that may facilitate an elopement of a resident or that may affect the staff's ability to respond.
3. On assisted living, if a resident begins to without regard to his or her safety or exits the community and is unable to find her way to the community, a new Risk Scale needs to be completed. . .
4. Utilize a routine maintenance check; (i.e checklist) to ensure that all alarm systems and windows restrictors are corking properly.
5. Maintain and communicate to staff, concierge, the names of the residents who may be a potential risk. Communicate this information on a routine basis to all community staff (stand -up meetings, department meetings, etc). A binder will be maintained at the reception a desk containing a copy of each resident's ID, Emergency sheet, and a current photo for emergency purposes. All resident photos need a close up of the resident's and should be updated with every 6 months with care plan updates.
6. Resident check procedures will be initiated and documented by the Director, Health & Wellness as needed on any resident who may be a potential /elopement risk. It is the responsibility of the DHW or designee to conduct follow up assessments and service plan modifications as required. . .
8. Resident monitoring systems and response procedures will be part of a general orientation training for all staff."

A record review on at 2:20 p.m. of the Quarterly Elopement Drill Standard issued , and last reviewed on .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 032	Continued From page 23 Standard: To ensure all that Experience Senior Living (ESL) communities are prepared in the event a resident is identified as missing, a company-wide quarterly drill process and schedule has been established to be carried out at each community. The goal of the quarterly drill is to review community systems currently in place, evaluate staff's preparedness, revise areas that may compromise the effectiveness of the search process, and to proactive/promote the most efficient process possible. Procedure: 1. The Vice President, Health &Wellness will establish the annual drill calendar, first month of each quarter, rotating shifts each quarter. . . 4. The missing person Checklist (steps - only) will be followed to ensure that all steps of the actual elopement event, other than outside parties are completed. . . 6. Copies of the missing person response procedure will be handed out and utilized by the team. 7. The Executive Director will complete a Quarterly Elopement Drill Evaluation Form within 24 of the drill and e-mail results to the Vice-President, Health & Wellness for review. 8. The Executive Director will verify that the missing person Checklist includes current contact information for department heads in steps and EVPO/VPHW in steps 30-31. Missing or inaccurate info shall be corrected. The Missing Person checklist & Quarterly Elopement Drill form shows step 5: "The Executive Director, Manager on Duty or Director, Health & Wellness will assign, at a minimum, one team member to search the exterior of the community and two team members to search the interior, beginning with the missing resident's	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 032	Continued From page 24	A 032		

room." Step 9 is to "Assign a team member to perform a headcount using the Resident Roster, accounting for each resident and verifying the identity of the missing resident."

1. Record review shows that Residents #11 and #12 eloped from Memory Care Unit using emergency door on at 6:45 p.m. Memory Care Caregivers Staff X and Y responded to door alarm and went to through vestibule to the next door that opens to outside of building and looked for whoever went out the door. They did not search outside. Memory Care Caregivers Staff X and Y returned and reported that they did not see anyone outside the door. A count was done and revealed that two residents were missing. A search was carried out and found Resident #12 in the parking lot. At this same time the police returned with Resident #11 who had been picked up after being discovered by a family several blocks away and contacted the police. Chiquita Blvd is a major 4 lane thoroughfare with heavy traffic.

Record review found that Resident #11 was admitted to the facility on . The only Health Assessment (HA) Form 1823 on record for Resident # 11 that was received by the facility on ; was incomplete in reference to resident's elopement. The elopement risk left blank. Under diagnosis the resident was listed as having a diagnosis of without behaviors disturbance. Resident #11 eloped from the facility on . There was no evidence that facility complete the risk within the first 24 hours of move in.
Furthermore, there was no evidence that facility completed an individualized service plan appropriate for the resident. There was no

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 032	Continued From page 25	A 032		

evidence that Resident #11 was re-assessed after the elopement that took place on . There was no evidence that Resident #11's Health Assessment Form 1823 was modified to include that Resident #11 was an elopement risk.

Resident# 12 was admitted to the facility on . Per Health Assessment (HA) Form 1823 (dated) on record Resident #12 had a diagnosis of . Resident#12 was not deemed at risk of elopement. Resident #12 was eloped from he facility on . There was no evidence that facility complete the risk within the first 24 hours of move in. Furthermore, there was no evidence that facility completed an individualized service plan appropriate for the resident. There was no evidence that Resident#12 was re assessed after the elopement that took place on . There was no evidence that Resident #12's Health Assessment Form 1823 was modified to include that Resident #12 was an elopement risk.

2. Record review showed that Resident #13 walked out the Memory Care Unit emergency exit door on at 5:10 a.m. Memory Care Caregiver Staff U and Licensed Practical Nurse (LPN) Staff V investigated the alarm and did not see anyone outside. They did not search outside. A room investigation and count was completed and determined the Resident 13 was missing. A facility search was initiated and Resident #13 was located by Memory Caregiver Staff U on the sidewalk south of the memory care exit door. Resident #13 was down on the sidewalk. Memory Caregiver Staff U radioed for assistance and LPN Staff V went to the location and assessed the resident. Resident #13 was observed by nurse to have from the and right-side , . was contacted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 032	Continued From page 26 and transported the resident to hospital by ambulance. Resident #13 was admitted to the facility on 11/3/21. Per the Agency for Health Care Administration Health Assessment Form 1823 review on record (dated) resident had a diagnosis of and was deemed as elopement risk. The only risk plan for resident that was provided by the facility was dated and indicated the resident was not an elopement risk. Resident #13 eloped from he facility on . Per record review Resident #13 was found in laying on the sidewalk down with noted on the and around the and . Resident #13 was noted hour prior to going missing. When he was a found the resident was observed without any care products pants, socks, or shoes. The resident only had a T-shirt on at the time he was found. Record review for Resident # 13 found no evidence he was re-assessed after the elopement that took place on . There was no evidence of updated risk plan for Resident #13 on record. 3. Observation of Memory Care exit door on at 1:45 p.m. with the Maintenance Director (MD) demonstrated that the door had a 15 second release and alarm. After pressing for 15 seconds the door released and the alarm sounded. Alarm was very loud. Passing through that door there is a second door that is alarmed with no panic bar. This door can be opened freely from the inside and has an alarm that is equally as loud as the first one. Walking through that door looking left you see a grassy area leading to the courtyard. Looking right you see a sidewalk approximately 10 to 15 yards long	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 032	Continued From page 27	A 032		

leading into the parking lot. Resident #13 would have been found on this sidewalk just south of this exit door. Residents #11 and #12 would have gone on to the parking lot and Resident #12 continued down the street for several blocks. Going left from parking lot takes you to a major intersection of two 4 lane roads. Going to the right takes you past several side street intersections.

4. Interview on [redacted] at 12:00 p.m., Memory Care Wellness Nurse Staff O said she has worked in the facility for 2.5 months. She did not have a list of residents at risk for elopement and assumed all the residents in the memory care would be at risk for elopement or exit seeking but wasn't sure.

Interview on [redacted] at 1:25 p.m., Memory Care Caregiver Staff P said he has worked for the facility for 2 months. He stated he has not had elopement training and works the 3:00 p.m. to 11:00 p.m. shift. He checks on his residents every two hours because he was trained to do that at his last job. Contacting the nurse is the first thing he does if he cannot locate one of his residents. He wasn't aware of any elopement risks but pointed to a male resident and believed he was someone to be watched.

Interview on [redacted] at 1:35 p.m., Memory Care Caregiver Staff A said she has worked at the facility for 6 months and reports she has not done an in-house elopement training but has done online generic training. Checking her residents all throughout her shift by being in their rooms, dining room, seeing them in the hall and activities is her way of doing things but has no scheduled time to check on her residents. If a resident is reported missing, she calls her supervisor, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 032	Continued From page 28	A 032		

they make the calls to management and the police. She isn't aware of anyone who is an elopement risk right now and didn't see anyone with a bracelet to show they were at risk.

Interview on [redacted] at 1:45 p.m., Memory Care Caregiver Staff Q said she has worked for the facility for 3 years and works 1st and 2nd shift due to her family schedule. She checks up on her residents frequently during her shift by being around them and assisting in their rooms and seeing them in the hallway. If someone elopes, she informs the Unit Manager who takes care of notification of managers and calling 911. She learns about elopement risk residents from her shift change meetings before her shifts and is not aware of anyone at risks at this time. She participates in the monthly elopement drills with all staff.

Interview on [redacted] at 2:00 p.m., Memory Care Caregiver Staff B said she has worked here for 6 months. She indicated that she has no set time to check on residents, but she checks all the time by seeing them in the hall or common areas and she knows the ones that like to nap in their room. She uses the MOR to look at the pictures of the residents and check notes to see who is at risk for elopement.

Interview on [redacted] at 3:15 p.m., Memory Care Caregiver Staff S said she has worked at the facility for 6 months and works 3 p.m.-11 p.m. and has picked up 11 p.m.-7 a.m. She has not had elopement training. Every 20 minutes to an hour she looks for her residents to make sure they are ok. She motioned to a table of residents and described one male resident and one female resident who she felt was at risk for elopement. When the alarm goes off, she goes to apartments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 032	Continued From page 29 to check on residents. Interview on at 3:20 p.m., Memory Care Caregiver Staff R said she has worked for the facility for 1.5 months on the 3 p.m. to 11 p.m. shift. She has been trained on the elopement policy when she was hired and has not been here long enough to do other trainings. She checks on her residents every 15-20 minutes. She would let the nurse know when an alarm goes off and the nurse would call 911 if necessary. Interview on at 3:25 p.m., Memory Care Caregiver Staff W said she has worked for the facility for 8 months and works the 3 p.m. - 11 p.m. shift. She checks her residents every 2 hours and or more frequently due to passing meds and taking them to activities and showers. 6. During an interview with Executive Director on at 1:01 p.m. ED confirmed that the staff were not educated on elopement based on the company policy and procedures and did not have evidence of completion based on their own P&P. 7. Interview on at 11:00 a.m. with Maintenance Director (MD) verified no resident elopement interventions or education was put in place following the elopement. A review of the facility elopement education shows that elopement training was done on , , , , and . The MD verified that the second alarm on the Memory Care exit door was not added until after the second elopement on and the same type of alarm was not added to the second Memory Care exit door leading to the outside until during the survey. 8. A review of the Elopement Drills and personnel	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 032	Continued From page 30 list revealed 45 direct caregivers and administrative staff hired from to . Of those 45 staff, only 6 had attended 2 elopement drills in 2023; 12 staff had attended 1 drill in 2023, and 27 had not attended any Elopement drills. Class III	A 032		
A 052 SS=E	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 052	Continued From page 31 or her . (d) Applying medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 052	Continued From page 32	A 052		

administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.
(5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.

59A-36.008
(3) ASSISTANCE WITH SELF-ADMINISTRATION.
(a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule.
(b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 052	Continued From page 33 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interviews with staff, the facility failed to ensure that unlicensed staff (Staff B) followed policy and provided a safe and sanitary environment by	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 052	Continued From page 34 utilizing proper hygiene techniques for 4 (Residents #19, #23, #24, and #27) of 4 residents observed, and failed to provide assistance with self-administration instead of administration of medications for 2 (Residents #24, and #27) of 4 residents observed. The findings included: 1. On at 12:00 p.m., Medication Technician (Med Tech) Staff B was observed preparing Solution 0.06% to be given 2 puffs in each nostril three times a day for Resident #19 without hygiene being performed before passing medication to the resident. Staff B was then observed opening the inhaler for the resident and then Staff advised the resident that they were getting their spray. They then administered the spray into the resident's nostrils and returned the inhaler to the medication cart without performing hygiene after the medication pass. 2. On at 12:05 p.m., Med Tech Staff B was observed without first performing hygiene prior to assisting Resident #23 with their medication. Staff prepared the tablet 10mg to be given 1 tablet by every day at noon for the resident and placed it in a medication cup. Staff failed to advise the resident of the medication name and dosage and gave medication cup to the resident for self-administration and then returned the medication to the cart. Staff observed the resident taking the medication and returned to the medication cart without performing hygiene after the medication pass. 3. On at 12:10 p.m., Med Tech Staff B	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 052	Continued From page 35 was observed without using proper hygiene prior to assisting Resident #24 with their medication. Staff improperly crushed a tablet 20mg ordered to be given 1 tablet by every day at noon and mixed it into a spoonful of applesauce and then put that spoon into the resident's without advising the resident of the medication name and dosage. Staff then returned to the cart without performing proper hygiene after the medication pass. 4. On at 12:35 p.m., Med Tech Staff B was observed without using proper hygiene prior to assisting Resident #27 with medication. Staff prepared PRN (pro re nata meaning as needed) and mixed the medication into a spoonful of applesauce and put that spoon into the resident's . Staff then returned to the cart without performing proper hygiene after the medication pass. 5. During an interview on at 12:15 p.m., Med Tech Staff B confirmed that they received their annual 2-hour recertification for medication administration and was educated to use proper hygiene techniques when assisting with medications. Staff then admitted that they did not have -based rub on their cart or on their person to perform hygiene when assisting Residents #19, #23, #24, and #27 with their medications. 6. During an interview on at 2:40 p.m., the Director of Health and Wellness confirmed that Staff B did not adhere to policy when they improperly crushed Resident #24's medication without a crush order, and when they administered Resident #24 and #27's medications into their on a spoon with applesauce, and when they did not perform	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 052	Continued From page 36 hygiene between giving Residents #19, #23, #24, and #27 their medications. Class III	A 052		
A 077	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	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 37	A 077		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 38	A 077		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 39 =Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure 1 (Administrator) of 1 staff reviewed, had documentation of high school diploma or equivalent as required. The Findings included: Review of Administrator's employee record on showed no documentation of high school diploma or equivalent. During an interview on at 12:05 p.m., the Business Manager confirmed that there was no documentation of a high school diploma or equivalent for the Administrator within their employee file. Class III	A 077		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 078	Continued From page 40 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 078	Continued From page 41	A 078		

agency or contractor will provide to residents.
(e) For facilities with a licensed capacity of 17 or more residents, the facility must:
1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,
2. Maintain time sheets for all staff.
(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.

This Statute or Rule is not met as evidenced by:
Based on record review, and interview, the facility failed to ensure for 2 (Administrator, and Staff I) of 5 staff reviewed, that within 30 days of employment staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable . This has the potential to put a population at risk of developing communicable .

The findings included:

Review of the Administrator's employee file on ., showed a hire date of .. Review of Administrator's employee file did not contain a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable .

Review of Staff I's employee file on ., showed a hire date of . Review of Staff I's employee file did not contain a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable .

During an interview on at 12:05 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 078	Continued From page 42 the Business Manager confirmed that no documentation of freedom from communicable [redacted] was on file for the Administrator or Staff I. Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 081	Continued From page 43	A 081		

living facility employees who have not previously completed core training as detailed in subsection (1).
(b) New staff must complete the preservice orientation prior to interacting with residents.
(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.
(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:
1. Resident's rights; and,
2. The facility's license type and services offered by the facility.
(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:
(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting adverse incidents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 081	Continued From page 44 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 081	Continued From page 45	A 081		

This Statute or Rule is not met as evidenced by:
Based on record review, and interview, the facility failed to ensure for 4 (Administrator, Staffs B, Z, and R) of 5 staff reviewed, complete Elopement Response training; 1 hour of Reporting Major Incidents. Reporting Adverse Incidents. Facility Emergency Procedures. Incident Reporting training; 1 hour of Resident Rights and Recognizing/Reporting /Neglect training; 2 hours of Preservice Orientation prior to interacting with residents; and for 3 (Staffs Z, B, and R) of 5 staff reviewed, complete 3 hours of in-service training for Activities of Daily Living and Behavioral Needs; and 1 hour of Control training.

The findings included:

Review of Staffs I, Z, B, and R's employee record on showed a hire date of , , and respectively.

Review of Administrator, direct care Staff B, Staff Z, and Staff R's employee record on contained no documentation for completion of Elopement Response training; Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures. Incident Reporting training; Resident Rights and Recognizing/Reporting /Neglect; and Preservice Orientation prior to interacting with residents.

Review of direct care Staff Z, Staff B, and Staff R's employee record on contained no documentation for completion of Control training; ADL and Behavioral Needs training prior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 081	Continued From page 46 to interacting with residents. During an interview on at 12:05 p.m., the Business Manager confirmed the Administrator, direct care Staff B, Staff Z, and Staff R, did not have the required training prior to providing direct/personal care with residents. Class III	A 081		
A 082	59A-36.011(4) FAC Training - [illegible] (4) [illegible] ([illegible]). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on [illegible] and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that 4 (Staffs I, Z, B, and R) of 5 staff reviewed completed the required and education course within 30 days of employment. The findings included: Review of Staff I's employee file on showed a hire date of . Review of their file contained no documentation of required	A 082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 082	Continued From page 47 / training. Review of Staff Z's employee file on :23 showed a hire date of . Review of their file contained no documentation of required / training. Review of Staff B's employee file on showed a hire date of . Review of their file contained no documentation of required / training. Review of Staff R's employee file on showed a hire date of . Review of their file contained no documentation of / training. During an interview on at 12:05 p.m., the Business Manager confirmed that there was no documentation of the required / training within the employee files. Class III	A 082		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 084	Continued From page 48	A 084		

requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance.
(b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to:
1. Read and understand a prescription label;
2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including:
a. Assist with oral dosage forms, , dosage forms, and , , and dosage forms;
b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;
c. Recognize the need to obtain clarification of an "as needed" prescription order;
d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 084	Continued From page 49 employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , , rate, temperature, and rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 084	Continued From page 50 effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that 1 (Staff B) of 5 staff reviewed had adequate Medication Training and Updates training documentation as required for unlicensed staff. The findings included: Review of the employee file on showed Staff B was hired on , as a Medication Assistant. Review of their file showed no documentation of Medication Training and Updates training by a registered nurse or licensed pharmacist. During an interview on at 12:05 p.m., the Business Manager confirmed that there was	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 084	Continued From page 51 no documentation of adequate training within their employee file. Class III	A 084		
A 086	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , and , shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas: 1. Understanding and related ; 2. Characteristics of ; 3. Communicating with residents with ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both	A 086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 086	Continued From page 52 the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing	A 086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 086	Continued From page 53	A 086		

education for extended congregate care required by subsection (7) of this rule.
(f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents.
(g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and:
1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or
2. Three years of practical experience in a program providing care to persons with or related , or
3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related .
(h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g).

This Statute or Rule is not met as evidenced by:
Based on record review, and interview, the facility failed to ensure for 4 (Staffs I, Z, B, and R) of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 086	Continued From page 54	A 086		

staff reviewed, completed the required 4-hour in-service training for Training Level I within 3 months of hire, and for 4 (Staffs I, Z, B, and R) of 5 staff reviewed complete Training Level II within 9 months of hire for facilities advertising special care to residents with and related (ADRD), or who have secure areas, staff who have regular contact and/or provide direct care to residents with ADRD. This has the potential to put populations at risk.

The findings included:

Review of Staff I's employee record on indicated a hire date of , as Director of Health and Wellness. Review of their file contained no documentation for completion of the 4-hour Training Level I and no documentation for completion of Level II training prior to interacting with residents within 9 months of hire.

Review of Staff Z's employee record on indicated a hire date of , as a Medication Assistant. Review of their file contained no documentation for completion of the 4-hour Training Level I and no documentation for completion of Level II training prior to interacting with residents within 9 months of hire.

Review of Staff B's employee record on indicated a hire date of , as a Medication Assistant. Review of their file contained no documentation for completion of the 4-hour Training Level I and no documentation for completion of Level II training prior to interacting with residents within 9 months of hire.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 086	Continued From page 55 Review of Staff R's employee record on indicated a hire date of , as a Medication Assistant. Review of their file contained no documentation for completion of the 4-hour Training Level I and no documentation for completion of Level II training prior to interacting with residents within 9 months of hire. On at 12:05 p.m., the Business Manager confirmed Staff I, Staff Z, Staff B, and Staff R did not have the required training prior to providing direct/personal care for residents with ADRD within 9 months of hire. Class III	A 086		
A 090	59A-36.011(11) FAC Training - Do Not Orders (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by:	A 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 090	Continued From page 56 Based in record review, and interview, the facility failed to ensure that 4 (Staffs I, Z, B, and R) of 5 staff reviewed had the required 1-hour in-service training on ( ) within 30 days after employment. The findings included: Review of Staff I's employee record on showed a hire date of , as the Director of Health and Wellness. Review of their file contained no documentation of the required training. Review of Staff Z's employee record on showed a hire date of , as a Medication Assistant. Review of their file contained no documentation of the required training. Review of Staff B's employee record on showed a hire date of , as a Medication Assistant. Review of their file contained no documentation of the required training. Review of Staff R's employee record on showed a hire date of , as a Medication Assistant. Review of their file contained no documentation of the required training. During an interview on at 12:05 p.m., the Business Manager confirmed that Staff I, Staff Z, Staff B, or Staff R did not have the required documentation of training within their files. Class III	A 090		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff	A 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 161	Continued From page 57	A 161		

429.275
(2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule.

59A-36.015
(2) STAFF RECORDS.
(a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . . . . . In addition, records must contain the following, as applicable:
1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C.,
2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,
3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C.,
4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C.,
5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c),

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	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 161	Continued From page 58 F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and interview, facility failed to ensure that 1 (Administrator) of 5 staff reviewed had required documentation of staff records containing an adequate job application and references, or job description. The findings included: Review of employee file on showed no documentation of job application and references, or a job description for the Administrator. During an interview on at 12:05 p.m., the Business Manager confirmed that there was no documentation of a job application and references, or job description for the Administrator within their employee file. Class III	A 161		
A 167 SS=D	59A-36.018 FAC; 429.24 FS Resident Contracts 59A-36.018 Resident Contracts.	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 167	Continued From page 59	A 167		

(1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions:
(a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services that the resident elects to receive;
(b) The daily, weekly, or monthly rate;
(c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract;
(d) A provision stating that at least 30 days written notice will be given before any rate increase;
(e) Any rights, duties, or of residents, other than those specified in section 429.28, F.S.;
(f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments;
(g) A refund policy that must conform to section 429.24(3), F.S.;
(h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 167	Continued From page 60	A 167		

party to act on the resident's behalf;
(i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility;
(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect;
(k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule;
(l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and,
(m) The facility's policies and procedures related to a properly executed DH Form 1896, [redacted].

(2) The resident, or the resident's representative, must be provided with a copy of the executed contract.
(3) The facility may not levy an additional charge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 167	Continued From page 61	A 167		

for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative.

429.24 FS
(1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration.

(2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 167	Continued From page 62	A 167		

require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period:
(a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident.
(b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits.

(3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or . . .
(b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee.
(c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 167	Continued From page 63 (4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility. (5) Neither the contract nor any provision thereof relieves any licensee of any requirement or [illegible] imposed upon it by this part or rules adopted under this part. (6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055. (7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's [illegible] or relocation due to [illegible] hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure the contract contained all required information.	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 167	Continued From page 64 The findings included: A review of the contract revealed the following missing information per Florida Statutes (FS) 429.24, and Florida Administrative Codes (FAC) 59A-36.018. and 59A-36.006(3)(a) 5, 1. Specialty diets the facility will provide. 2. Explaination of services levels I - . and custom. 3. Explaination of the special services and accomodations for the residents of the Memory Care Unit as required by 429.177 and 59A-36.006(3)(a)13. 4. Purpose of the Community fee on page 9 of the contract. 5. Purpose of the fee under Exhibit G. 6. Page 6 of the Contract lacked the requirement for a Health Assessment Form 1823 every 3 years. 7. Exhibit M refers to medication administration rather that assistance with self-administration, and lacked the informed consent information and over-the counter medication polcy and procedure. 8. procedure does not include printing the form on yellow paper. 9. Exhibit B Additional Services (ancillary charges) sheet did not include specific prices as required by F.S. 429.24 and F.A.C. 59A-36.006(3)(a)7. and 59A-36.018(1)(c), rather it quoted "Market Price" or "Prices vary per service" or "per item", or "per distance". For Care Exhibit B shows, "Specific pricing and accomodations pertaining to care support will be determined by the Community." Further a room service charge found on page 4 of the contract, a maintenance fee found on page 4 of the contract, and a housekeeping fee found on page 5 opf the contract were not included on Exhibit B.	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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A 167	Continued From page 65 During an interview on at approximately 3:45 p.m., the administrator said the admission packet was complete and up-to-date. Class III	A 167		

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
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure 1 (Administrator) of 5 staff reviewed, had Level 2 background screening employment status updated within 10 business days on the Agency's Background Screening Clearinghouse (Clearinghouse) website. This has the potential for staff with disqualifying offenses to have access to adults. The findings included: Record review on of the Clearinghouse Employee Roster indicated the Administrator was hired on and added to the roster on . During an interview on at 12:05 p.m., the Business Manager verified they are responsible for adding employees to the Clearinghouse and acknowledged that the Administrator was not added to the	CZ814		

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
	AL11969737	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

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CZ814	Continued From page 2 Clearinghouse within the required timeframe. "Photographic evidence obtained." Unclassified	CZ814		