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
	AL11969902	A. BUILDING: _____ B. WING _____	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPY FAMILY ALF	322 CAPE CORAL PKWY W CAPE CORAL, FL 33914

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] 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 [illegible], 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 [illegible], 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 [illegible], 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

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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 interview, the facility failed to maintain the employment status of all employees within the Background Screening Clearinghouse and report any changes of status within 10 business days for 1 (Staff A) of 4 employees reviewed for the Background Screening Clearinghouse. The findings included: Record review of Staff A's employee file revealed a hire date of as a caregiver. Staff A was added in the facility background screening Clearinghouse on , 39 days after hire. During an interview on at 3:30 p.m., the Administrator acknowledged Staff A was not listed in the Clearinghouse within the 10 days as required. Unclassified	CZ814		

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A 000	Initial Comments An unannounced relicensure, emergency power plan, health facility reporting system, generator, and visitation form survey was conducted on at Happy Family ALF, an assisted living facility in Cape Coral, Florida. Capacity increase is recommended. The following is a description of the deficiencies.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who	A 010		

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A 010	Continued From page 3	A 010		

requires the use of assistive devices.
(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical .
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney

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A 010	Continued From page 4 in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care,	A 010		

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A 010	Continued From page 5 or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily	A 010		

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A 010	Continued From page 6 living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents admitted to the facility met criteria for admission and the continued appropriateness of residency for 1 (Resident #5) of 3 residents reviewed. The findings included: A review of the facility's Agency for Health Care Administration license showed they have a Standard license. An observation was conducted on . . . . . from 9:00 a.m. through 12:30 p.m. of Resident #5. She was observed laying in the bed in a hospital gown, The side rails were observed to be in the upward position. Resident #5 did not get up from the bed She did not participate in any of the activities or watch television. She slept most of this time. On at 12:16 p.m., Resident #5 was observed in bed wearing a hospital gown, no participation in activities observed. On at 12:25 p.m., Staff B stated Resident #5 is not able to do anything for herself. The staff feed her, and she is currently bed bound. Staff B stated Resident #5 is not on hospice and is not able to assist with transfers or feeding herself. Staff B said Resident #5 had been in that condition from the time she started working at the	A 010		

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A 010	Continued From page 7 facility last year, and has always been total assist. Staff B stated Resident #5 gets bed baths as she can't assist with her showers and can't help with changing her depends, the staff change the depends for her. Staff B said she is total care and the staff does all of her activities of daily living (ADL) for her. On . . . . at 12:25 p.m., Staff B was observed to enter Resident #5's room. Resident #5 was still in bed asleep in a hospital gown. Staff B called Resident #5 by name and told her it was time for lunch, with no answer. Staff B rubbed Resident #5's ˬ with no answer, she did not move. On . . . . at 12:30 p.m., Staff B and Staff A were observed to physically lift Resident #5 from the bed and transferred her to the recliner next to the bed, seating her in the upright position, Resident #5's . . . were dragging on the ground during the transfer as she was not able to assist and lift her . . . . Resident #5 did not assist staff to stand or pivot. Resident #5 was . . . . ˬ . . . ˬ when transferred from the bed by Staffs A and B, and did not assist in seating herself upright. Resident #5 did not participate in this transfer. The staff provided total assistance for Resident #5 with the transfer. On . . . . at 12:45 p.m., Staff B was observed to spoon feed Resident #5 her pureed lunch. Resident #5 swallowed 3 spoonfuls of the meal. Resident #5 did not have a utensil in her . . to eat her meal or cup in her . . to drink. Staff B provided total assistance to Resident #5 to eat her lunch and drink her liquids. On . . . . at 12:50 p.m., the Administrator stated the facility had no order for pureed meals	A 010		

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A 010	Continued From page 8 for Resident #5. On [redacted] at 1:05 p.m., Staff A stated Resident #5 has been total care since she was admitted to the facility. Staff A said staff have to lift her for transfers, feed her, and assist her with showers, [redacted], and toileting. She is not able to assist with any of her ADL's and is bed bound. Record review of Resident #5's clinical chart revealed she was admitted to the facility on [redacted]. Further review revealed 3 health assessments dated [redacted], [redacted] and [redacted] which indicated Resident #5 required total assistance with ambulation, bathing, [redacted], eating, self-care (grooming), toileting and transferring, and was on a regular diet. Further review of Resident #5's record showed there was no 45-day discharge notice. On [redacted] at 1:19 p.m., the Administrator confirmed Resident #5 has been total assist since admitted to the facility. Resident #5's condition has deteriorated and Resident #5 has declined for the last 2 months. The Administrator stated Resident #5 is not in hospice services. The Administrator confirmed Resident #5 requires total assistance with her activities of daily living (ADL) and is not able to help the staff with any of her ADL's. On [redacted] at 1:50 p.m., the Administrator reviewed the clinical record for the Resident #5 and confirmed there were no orders for side rails, no hospice orders, and there was no consent for side rails. The Administrator confirmed the health assessment and all documentation indicated Resident #5 needed total assist by the facility staff and she currently does not meet criteria for the facility.	A 010		

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A 010	Continued From page 9 Class III .	A 010		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), 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.	A 032		

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A 032	Continued From page 10 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure 5 (Staffs A, B, C, D, E) of 5 staff reviewed for participation and documentation in Elopement drills on each shift twice annually in accordance regulations pursuant to sections 429.41(1)(a) and 429.41(1)(k). F.S. which requires Facilities to document participation in the drills.	A 032		

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A 032	Continued From page 11 The findings included: Review of Facility policy, Elopement Missing Resident Drill Procedures: It is the policy of Happy Family ALF (Assisted Living Facility) to conduct elopement drills twice a year. All staff will be trained within 30 days of their hire date and then every year thereafter. On , record review of facility records, revealed documentation of elopement drills on , and , 4 staff members were not documented as participating in any of the elopement drills. Review of the employee list revealed Staff A was hired on . Staff A is not listed as participating in any of the elopement drills performed in 2023. Review of the employee list revealed Staff B was hired on . Staff B is not listed as participating in any of the elopement drills performed in 2023. Review of the employee list revealed Staff C was hired on . Staff C is not listed as participating in any of the elopement drills performed in 2023. Review of the employee list revealed Staff D was hired on . Staff D is not listed as participating in any of the elopement drills performed in 2022 or 2023. Review of the employee list revealed Staff E was hired on . There was no documentation in the employee record for Staff E indicating participation in any elopement drills at the facility.	A 032		

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A 032	Continued From page 12 During an interview on at 2:00 p.m., the Administrator confirmed no staff names and/or signatures are listed on the elopement drills completed to document staff participation in the elopement drills. She stated the Consultant did the elopement drill forms and she was not told her about having staff signatures and/or names on the list when they participated in the drills. Class III .	A 032		
A 052 SS=D	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	A 052		

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A 052	Continued From page 13	A 052		

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 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

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	AL11969902	A. BUILDING: _____ B. WING _____	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPY FAMILY ALF	322 CAPE CORAL PKWY W CAPE CORAL, FL 33914

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A 052	Continued From page 14 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 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	A 052		

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A 052	Continued From page 15 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 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:	A 052		

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A 052	Continued From page 16 Based on observation, record review, and interview, the facility failed to ensure staff who assist with self-administration of medications do so in accordance with proper procedure for 3 (Residents #6, #7, #8) of 3 medication observations. The findings included: Facility policy titled, Informed Consent to Assistance with Medications by Unlicensed Personnel: . . . Assistance with self-administration of medication includes: (a) Taking the medications in its previously dispensed properly labeled container from where it is stored and bringing it to the resident. . . (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. . . (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 or her . (d) applying medications. (e) Returning the medication container to proper storage. Facility policy titled, Control (Universal / Precautions)included objective: 1. Prevent the spread of germs and using the correct techniques for hygiene. Under Wash : Wash your with soap and water: 2. Before putting on and taking off gloves. . . 4. Before preparing medication. On at 9:20 a.m., Staff B, Medication Technician (MT) was observed assisting Resident	A 052		

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A	Continued From page 17 #8 with medications. Staff B donned gloves, unlocked and opened the medication cabinet. Staff B tore off a package containing Resident #8's medication from a box in the medication cabinet. Staff B opened the package and removed 1 pill from the package, placing it in a glass bowl in the cabinet. Staff B walked the package to Resident #8's room and gave him the package with pills and observed him take the medications. Staff B left the medication cabinet door open and unlocked with the cabinet being out of her sight. Staff B walked . . . to the living room, doffed the gloves, and signed the medication observation record (MOR). No . . hygiene was performed. Staff B did not inform Resident #8 what medications he was given and did not perform hygiene prior to and after doffing gloves and proceeded to the next resident. Staff B again left the medication cabinet open and unlocked while she was out of sight of the cabinet. On . . . at 9:28 a.m., Staff B, MT was observed assisting Resident #6 with medications. Staff B donned gloves, unlocked and opened the medication cabinet. Staff B tore off a package containing Resident #6's medication from a box in the medication cabinet. Staff B went to the kitchen cabinet, removed a cup and filled it with water at the kitchen sink for Resident #6. Staff B removed gloves and donned new gloves. Staff B did not perform hygiene. Staff B took the cup and package with pills into living room area and poured the pills into Resident #6's , and observed her take the medications. Staff B left the medication cabinet door open and unlocked with the cabinet being out of her sight. Staff B walked to living room, doffed gloves, and signed the medication observation record (MOR). No hygiene was performed between	A 052		

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A 052	Continued From page 18 Resident's #6 and #8. Staff B did not inform Resident #6 what medications she was given and did not perform . hygiene prior to and after doffing gloves and proceeded to next resident. Staff B again left the medication cabinet open and unlocked while she was out of sight of the cabinet. On . . . at 9:40 a.m., Staff B, MT was observed assisting Resident #7 with medications. Staff B removed gloves from a box on the kitchen wall and donned gloves. No hygiene was performed. Staff B went to the medication cabinet, still open, tore off a package of medications from the container for Resident #7. Staff B opened the medication package and poured the meds into a pill crusher and crushed Resident #7's medications. Staff B went to the refrigerator, removed yogurt, and added the yogurt to Resident #7's medications. Staff B took the yogurt with the medications to living room where Resident #7 was seated and gave her the yogurt and walked . . to dining room and signed the MORs. Staff B did not perform hygiene after Resident #6 and prior to donning gloves and assisting Resident #7 with medication. Staff B did not inform Resident #7 what medications she was given. Staff B left the medication cabinet open and unlocked while she was out of sight of the cabinet. During an interview on at 9:47 a.m., Staff B stated she completed medication training. They discussed how to give the resident the medications, . washing, change gloves between residents, read the meds to the residents. Staff B states sometimes she reads the medications to the residents and sometimes she does not as she gets too busy. Staff B confirmed she did not read the medications to the residents,	A 052		

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A 052	Continued From page 19 and she donned and doffed gloves and did not perform hygiene between each resident. Staff B stated, "I was concentrating on getting the gloves on as it was too hard for me." Staff B confirmed leaving the medication cabinet unlocked and opened when it was out of her sight. During an interview on at 1:20 p.m., the Administrator stated when assisting with medications the staff are to wash their , put the gloves on, take the meds and water to the resident and explain to the resident what meds they are giving, put the meds in the resident and watch them take the meds, remove the gloves and wash their between each resident and then repeat for each additional resident, keeping the med cabinet locked when not in sight. On at 1:26 p.m., the Administrator confirmed Staff B did not follow the facility protocol when assisting with medications. Class III .	A 052		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good	A 152		

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A 152	Continued From page 20 working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [illegible] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible]. This Statute or Rule is not met as evidenced by: Based on observation, and interview, the facility failed to provide sleeping space separate from the sleeping and congregate space provided for residents, per Section 434 Florida Building Code for assisted living facilities. The findings included: On [illegible] at 8:30 a.m., upon arrival at the	A 152		

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A 152	Continued From page 21 facility, observation was made of 2 beds set up in the facility residents congregate living space, 1 size bed set up in the living room and 1 size bed set up in the dining room of the facility, Building A. During an interview on at 11:43 a.m., Staff B (Caregiver) stated the beds in the living room and dining room are for the staff to sleep, they do not have live in caregivers, but the staff sleep on the overnight shifts. Staff B states the residents do not sleep on the beds only the facility staff sleeps on the beds in the living room and dining room area. They sleep at night when the residents go to bed and get up when the residents get up. During an interview on at 1:05 p.m., Staff B confirmed the beds in the living room and dining room are for the staff to sleep on when the residents are sleeping. During an interview on at 1:15 p.m., the Administrator stated the beds in the dining room and living room are for the staff during the night or in the afternoon to sleep, she states only the staff uses them, they are not for the residents to use, they use them to sleep and watch television. During an interview on at 3:30 p.m., the Administrator acknowledged the beds for staff use should not be located in the resident's usable space in the dining room and living room. Class III .	A 152		