

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967495</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/08/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HAPPY LIFE ALF</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>14785 COOLIDGE LANE<br/>HOMESTEAD, FL 33033</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                     | Initial Comments<br><br>A re-licensure survey was conducted at Happy Life ALF on . . . . . Deficiencies were identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A 000                                                                                       |                                                                                                                          |                                                        |
| A 030<br>SS=D                                             | 59A-36.007(5) FAC; 429.28( ) FS 429.27<br>Resident Care - Rights & Facility Procedures<br><br>59A-36.007<br>(5) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(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 admission package provided pursuant to Rule 59A-36.006, F.A.C.<br>(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.<br>(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.<br>(d) The facility must have a written statement of | A 030                                                                                       |                                                                                                                          |                                                        |

AHCA Form 3020-0001  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| A 030                                                     | <p>Continued From page 1</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. Resident responsibilities;</li> <li>2. _____ and tobacco use;</li> <li>3. Medication storage;</li> <li>4. Resident elopement;</li> <li>5. Reporting resident _____, neglect, and _____;</li> <li>6. Administrative and housekeeping schedules and requirements;</li> <li>7. _____ control, sanitation, and standard precautions;</li> <li>8. The requirements for coordinating the delivery of services to residents by third party providers;</li> <li>9. Assistive devices; and</li> <li>10. Physical _____.</li> </ol> <p>(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.</p> <p>(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.</p> | A 030                                                                          |                                                                                                                          |  |                                                        |

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HAPPY LIFE ALF**

**14785 COOLIDGE LANE  
HOMESTEAD, FL 33033**

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| A 030                    | <p>Continued From page 2</p> <p>429.28 Resident bill of rights.-</p> <p>(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:</p> <p>(a) Live in a safe and decent living environment, free from . . . . . and neglect.</p> <p>(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.</p> <p>(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 personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(g) Share a room with his or her spouse if both</p> | A 030               |                                                                                                                          |                          |

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| A 030                                                     | Continued From page 3<br><br>are residents of the facility.<br>(h) Reasonable opportunity for regular exercise<br>several times a week and to be outdoors at<br>regular and frequent intervals except when<br>prevented by inclement weather.<br>(i) Exercise civil and religious liberties, including<br>the right to independent personal decisions. No<br>religious beliefs or practices, nor any attendance<br>at religious services, shall be imposed upon any<br>resident.<br>(j) Assistance with obtaining access to adequate<br>and appropriate health care. For purposes of this<br>paragraph, the term "adequate and appropriate<br>health care" means the management of<br>medications, assistance in making . . . . .<br>for health care services, the provision of or<br>arrangement of transportation to health care<br>. . . . ., and the performance of health<br>care services in accordance with s. 429.255<br>which are consistent with established and<br>recognized standards within the community.<br>(k) At least 45 days' notice of relocation or<br>termination of residency from the facility unless,<br>for medical reasons, the resident is certified by a<br>physician to require an emergency relocation to a<br>facility providing a more skilled level of care or the<br>resident engages in a pattern of conduct that is<br>harmful or offensive to other residents. In the<br>case of a resident who has been adjudicated<br>mentally . . . . ., the guardian shall be<br>given at least 45 days' notice of a nonemergency<br>relocation or residency termination. Reasons for<br>relocation must be set forth in writing and<br>provided to the resident or the resident's legal<br>representative. The notice must state that the<br>resident may contact the State Long-Term Care<br>Ombudsman Program for assistance with<br>relocation and must include the statewide toll-free<br>telephone number of the program. In order for a | A 030                                                                                       |                                                                                                                          |                                                        |

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| A 030                    | <p>Continued From page 4</p> <p>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.</p> <p>(1) 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.</p> <p>(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</p> | A 030               |                                                                                                                          |                          |

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| A 030                    | <p>Continued From page 5</p> <p>Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and . . . . , Rights Florida.</p> <p>429.27 Property and personal affairs of residents.-</p> <p>(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.</p> <p>(b) The admission of a resident to a facility and his or her presence therein shall not confer on the 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.</p> <p>This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide a 45-day notice of relocation or termination of residency from the facility for two out of six (Resident #6) sampled residents.</p> <p>Finding included:</p> <p>A review of Resident #6's progress notes showed that the resident was discharged on . . . .<br/>The record did not have documentation that the resident received a 45-day notice.</p> | A 030               |                                                                                                                          |                          |

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| A 030                                                     | Continued From page 6<br><br>A review of Resident #6's record showed the resident was admitted on _____. The health assessment done on _____ showed a diagnosis of _____, a history of left _____, and _____. The physician indicated the resident was independent with ambulation, eating, and transferring, needed supervision with bathing, self-care, and toileting, and needed assistance with _____. The resident was under elopement risk.<br><br>On _____ at 1:15 PM, the Administrator stated that she gave a 45-day notice to the resident but she was unable to provide the document during the survey.<br><br>Class III                                                                                                                                                     | A 030                                                                                       |                                                                                                                          |                                                        |
| A 078<br>SS=D                                             | 59A-36.010(2) FAC Staffing Standards - Staff<br>(2) STAFF.<br>(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.<br>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 | A 078                                                                                       |                                                                                                                          |                                                        |

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| A 078                                                     | <p>Continued From page 7</p> <p>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</p> <p>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</p> <p>(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.</p> <p>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.</p> <p>(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 agency or contractor will provide to residents.</p> <p>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:</p> <p>1. Develop a written job description for each staff</p> | A 078                                                                          |                                                                                                                          |                          |                                                        |



Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967495</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/08/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HAPPY LIFE ALF</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>14785 COOLIDGE LANE<br/>HOMESTEAD, FL 33033</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 078                                                     | <p>Continued From page 8</p> <p>position and provide a copy of the job description to each staff member; and,</p> <p>2. Maintain time sheets for all staff.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable _____ for one out of four (Staff C) sampled staff.</p> <p>Findings included:</p> <p>A review of Staff C's (caregiver) record revealed no documentation of a statement from a healthcare provider stating staff were free from communicable _____. Staff C was hired on _____.</p> <p>On _____ at 1:15 PM, the Administrator acknowledged that there was no written statement from a health care provider documenting that Staff C did not have any signs or symptoms of communicable _____.</p> <p>Class III</p> | A 078                                                                                       |                                                                                                                          |                                                        |
| A 165<br>SS=D                                             | <p>429.23( &amp; ) FS Risk Mgmt &amp; QA</p> <p>429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.-</p> <p>(1) Every facility licensed under this part may, as</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A 165                                                                                       |                                                                                                                          |                                                        |

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>HAPPY LIFE ALF</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>14785 COOLIDGE LANE<br/>HOMESTEAD, FL 33033</b>                              |  |                                                        |
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| A 165                                                     | <p>Continued From page 9</p> <p>part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.</p> <p>(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:</p> <p>(a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:</p> <ol style="list-style-type: none"> <li>1. _____ ;</li> <li>2. _____ or _____ damage;</li> <li>3. Permanent _____ ;</li> <li>4. _____ or _____ of bones or joints;</li> <li>5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;</li> <li>6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or</li> <li>7. An event that is reported to law enforcement or its personnel for investigation; or</li> </ol> <p>(b) Resident elopement, if the elopement places the resident at risk of harm or injury.</p> <p>(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse</p> | A 165                                                                          |                                                                                                                          |  |                                                        |

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| A 165                                                     | <p>Continued From page 10</p> <p>incident, and the status of the facility's investigation of the incident.</p> <p>(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.</p> <p>(6) _____, neglect, or _____ must be reported to the Department of Children and Families as required under chapter 415.</p> <p>(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.</p> <p>(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.</p> <p>(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and</p> | A 165                                                                          |                                                                                                                          |  |                                                        |

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| A 165                                                     | <p>Continued From page 11</p> <p>are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.</p> <p>(10) The agency may adopt rules necessary to administer this section.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on interview and record review, the facility failed to provide an initial adverse incident report within one business day after the incident and a full adverse incident report within 15 days of the incident through the agency's online portal for one out of six (Resident #6) sampled residents.</p> <p>Findings included:</p> <p>A review of Resident #6's record showed the resident was admitted to the facility on ..... The progress notes documented that the resident eloped from the facility on .....</p> <p>A review of the Adverse Incident Reporting System database showed no documentation that the facility filed a one-day and a 15-day report regarding Resident #6 elopement that happened on .....</p> <p>On ..... at 1:15 PM, the administrator stated Resident #6 left the facility on ..... The staff searched for the resident inside and outside the facility and did not find him. The staff notified the police. The owner found the resident a few blocks from the facility the same date. She acknowledged that she did not file an adverse incident report.</p> | A 165                                                                                       |                                                                                                                          |                                                        |

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HAPPY LIFE ALF**

**14785 COOLIDGE LANE  
HOMESTEAD, FL 33033**

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| A 165                    | Continued From page 12<br><br>Class III                                                                                      | A 165               |                                                                                                                          |                          |