STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967495	**05/03/2018**
NAME OF PROVIDER OR SUPPLIER **HAPPY LIFE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **14785 COOLIDGE LANE** **HOMESTEAD, FL 33033**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A Change of Ownership survey was conducted on , , 2018. Happy Life Alf Inc., with a Limited Mental Health component and license #11541, had the following deficiency identified at the time of the survey:

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the Assisted Living Facility failed to have a written statement from a health care provider documenting that one out of four sampled staff did not have any signs or symptoms of communicable (Administrator). The facility also failed to have documentation of a negative examination documented on an annual basis for one out of four sampled staff (Administrator).

Findings included:

Review of Administrator's personnel record revealed that her hire date was . There was no available written statement from a health care provider documenting that Administrator was free of communicable .

On at 10:04 AM the Administrator revealed that the health care provider was on vacation and would be back on , , 2018.

Class III