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
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 000	Initial Comments An unannounced licensure complaint survey (#2020011009 & #2020010991) was conducted at Courtyard Gardens Senior Living on & . . . . . The facility had deficiencies identified during the time of the survey.	A 000		
A 030 SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) 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 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	A 030		

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
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 1 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 universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (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. (g) In addition to the requirements of section	A 030		

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
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 2 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 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 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.	A 030		

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
	AL11969656	A. BUILDING: ____ B. WING ____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 3	A 030		

(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 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

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
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 4	A 030		

relocation shall be set forth in writing. 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.
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], 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 [illegible] or [illegible] 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 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 observation, interview, and record review the facility failed to safe guard the residents wellbeing by failing to implement control standards related to the COVID-19 as recommendations set forth by Centers for Control and Prevention (CDC) , the State of Florida Division of Emergency Management (Executive Order No. 20-52) and the Department of Health. The findings included:	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 6 The CDC documents individuals who are 65 years and older, those with underlying medical conditions, and those living in residential communities are at high risk for developing serious complications from COVID-19 illness. Individuals who are could develop serious with difficulty breathing, and might require intensive care for the treatment of multi-organ failure, , failure, and . COVID-19 can lead to . COVID-19 is a new , caused by a new Coronavirus that has not previously been seen in humans. Currently, there is no and no approved treatment for COVID-19 , which is a highly transmissible . See generally, Publications of the Centers for Control. The State of Florida Division of Emergency Management Executive Order No. 20-52 by the Public Health Emergency dated , prohibits all individuals from visiting facilities within the State of Florida. For purposes of this order, Assisted Living Facilities are included. Every facility must prohibit the entry of any individual, to the facility except in the following circumstances: end-of-life situations, providing necessary health care to a resident, and representatives of the federal or state government. Centers for Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated stated the following. Assisted living facility (ALF) Owners and Administrators should refer to guidance from state and local officials when making decisions about relaxing restrictions (e.g. easing visitor restrictions). Everyone in the facility should practice source control. Personnel should wear a facemask.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 7 The Facility's COVID-19 Policies and Procedures states the following. For visitors, it is important to note current Centers for Control (CDC) and state guidance requires ALFs to restrict visitors to only those who are providing critical assistance. Further review of the policy under section VIII Department of Health (DOH) with ALFs that have Positive COVID-19 Cases: For a report of a positive COVID-19 test (resident and staff) in an ALF will take the following actions: Verify the ALF is prohibiting non-essential visitors. In an observation during the entrance to the facility on . . . . . , this surveyor observed the Owner and a staff member walking into the facility. The Owner had his . . . mask around his not covering his or . The staff member had her . . . mask on. This surveyor entered the facility and after the screening process met with the Owner who at the time had his mask on his covering his and . . . . During a tour conducted with the Owner, this surveyor observed Staff I in the kitchen with no mask on. The Owner informed her to put her mask on. Also, during the tour Staff J was in her office with her . . . mask around her . . not covering her and . The Owner stopped to have a conversation with her. He did not encourage her to put her mask on. The ALF Owner failed to implement safety measures to protect residents and staff by not restricting visitation and failing to implement the facility's Policy regarding when COVID-19 is suspected and confirmed among residents or facility personnel. On . . . . . at 10:55 AM, an interview was conducted with the Owner. He stated that he had 3 staff members that tested positive for COVID-19. They all had minimal	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 8	A 030		

exposure to the facility, residents, and staff members. The following information was provided to this surveyor from the Owner:

a) On . . . . . Staff E had symptoms and she had herself tested. On she tested positive for COVID-19 and was admitted to the hospital. The Owner stated that he followed up with her husband and she was not doing so well. She has not returned to work.

b) On Staff F showed symptoms. He left the facility the same day. On . . . . . he tested positive for COVID-19. He has not returned to work.

c) On . . . . . Staff G showed no symptoms. On he was at the facility for 1 hour and had symptoms. He had a runny . . . and tickle in his . . . He called the Owner at 9:30 AM. The Owner told him to go home. He was told to everything and go home.

d) On all staff and residents were tested. 36 people were tested; in which 33 tests came and were negative. The Owner stated that they are still awaiting the results for 3 tests.

The Owner stated that tours are conducted at the facility for people who are in dire need. He stated that he has conducted a couple of tours for essential people. Tours are conducted with 1 person at a time. He stated that during a tour a review of the facility is conducted. There is a 1 hour sit down conversation in the conference room. The last tour was conducted on . He stated that as of . . . . . he was responsible for tours. Prior to that Staff H was responsible, but he is no longer at the facility. He stated that normally he has an Executive Director that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 9	A 030		

handles everything, and they relay the information to him. He stated that he is only at the facility because he does not have an Executive Director. He stated that normally the tours are conducted virtually. The tours are conducted every other week with 1 or 2 people at a time. He stated that he normally goes outside to speak with individuals. He stated he was not informed that he could not give tours and he has not contacted the state or local officials. He stated that DOH came out on . . . . . and stated no tours should be conducted. This surveyor informed the Owner that the visitation had been restricted for ALFs. The Surveyor provided the Owner with the Governor Order and CDC guidelines. The Owner later provided this surveyor with the facility's COVID-19 policy and procedures which stated a report of a positive COVID-19 test (resident and staff) in an ALF will take the following actions: Verify the ALF is prohibiting non-essential visitors.

On at 11:50 AM, an interview was conducted with Staff A. She stated that the staff received a letter that 2 people at the facility had tested positive for COVID-19 on . . . . . One week prior the staff was informed that 1 person tested positive for COVID-19. She stated no names were given. She stated that all staff and residents were tested on . . . . . for COVID-19 and they will receive the results on . She stated that previously they were conducting tours at the facility. She stated that a new Director came in 1 week ago and the tours were stopped. She stated that the Director is no longer at the facility and there have been no tours since then.

On . . . . . at 11:51 AM an interview was conducted with Staff B. She stated that the facility sent out an email that 3 people were confirmed that tested positive with COVID-19 on .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 10 They did not discuss names of the staff. She stated that the staff members are no longer at the facility. During a confidential interview conducted on at 2:40 PM, the following information was revealed. The employee confirmed employment at the facility. The employee confirmed the Owner was conducting tours in . The Owner was informed that he was not following the Agency for Health Care Administration (AHCA) guidelines by continuing to do tours at the facility. The Owner was conducting all the tours at the facility. The Owner would conduct tours with 2 to 3 people 5 days a week. The Owner was asked to stop doing tours, but he would not stop. It was revealed DOH came in during the week of . DOH informed the Owner to put his mask on. The tours being conducted at the facility were not mentioned to DOH. It was also revealed that one of the aides from the facility came and notified her/him that one of the staff members husband had called stating she was in the hospital and tested positive for COVID-19. Further interview with confidential source revealed she was responsible for updating the Emergency Status System (ESS) and the Owner never gave her that information. She informed him that he could be fined for putting fraudulent information into the ESS. He/she stated that one day the Owner came in and asked for the Visitor log. He/she told him that, if he defaces the information he could get in a lot of trouble. The Owner and Staff A provided this surveyor with the Visitor/Tour Log. The log showed that 7 tours had been conducted between - 1 to 2 visitors were involved in the tours.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969656	A. BUILDING: _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS SENIOR LIVING	3005 S CONGRESS AVENUE BOYNTON BEACH, FL 33426

(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 11 At the front entrance of the facility this surveyor observed no visitor signage posted. During an interview conducted on at 3:30 PM with the Owner, he acknowledged the findings and no additional information was provided. Class III	A 030		