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
	AL11965339	A. BUILDING: _____ B. WING _____	06/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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 Complaint Inspection survey (20200010454), with the Department of Health, was conducted on - at Courtyard Gardens of Jupiter. The facility had deficiencies at the time of the survey.	A 000		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes to have an emergency operations plan must designate a safety liaison to serve as the primary contact for emergency operations. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved emergency operations plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by	CZ830		

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CZ830	Continued From page 1 the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and review of Emergency Status System (ESS) data for 3 of 3 days (, , and), the Assisted Living Facility (ALF) failed to accurately report their number of total residents and staff who had tested positive for the COVID-19 .	CZ830		

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CZ830	Continued From page 2 The findings included: During the entrance conference on beginning at 9:16 AM, the Executive Director was asked to provide evidence of COVID-19 testing and results for both residents and staff. The Executive Director explained testing of all residents and staff was completed on , with positive results reported to the ALF verbally on , and again via email to the previous Director of Nursing on . The Executive Director then explained additional testing of all residents residing in the Azalea unit, along with staff that worked in that unit was completed by an outside laboratory on with results reported to the ALF on . Review of COVID-19 testing results and record review revealed the following regarding positive residents: A) Resident #2 who resided on the Azalea unit, was tested on with positive results reported to the ALF on by the DOH. Resident #2 , , on . B) Resident #3 who resided on the Azalea unit, was tested on with positive results reported to the ALF on by the DOH. A progress note dated documented Resident #3 complained of , and a and was sent to the hospital. C) Resident #4 who resided on the Azalea unit, was tested on with positive results reported to the ALF on by the DOH. A progress note dated documented Resident #4 was sent to the hospital for , decreased saturation levels, and not eating. D) Resident #5 who resided on the Azalea unit,	CZ830		

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CZ830	Continued From page 3 was tested on . . . . . with positive results reported to the ALF on by the DOH. A progress note dated . . . . . documented Resident #5 was , not eating well, had poor fluid intake and was sent to the hospital. E) Resident #6 who resided on the Azalea unit, was tested on . . . . . with positive results reported to the ALF on . . by the DOH. A progress note dated . . . . . documented Resident #6 was sent to the hospital related to . . . . . and a low saturation of 89% on room air. Resident #6 , on . . . . . . F) Resident #7 who resided on the Azalea unit, tested negative during the testing on . A progress note dated revealed Resident #7 was sent to the hospital due to , not eating, and a low saturation. The resident tested positive at the hospital on . G) Resident #8 who resided on the Azalea unit, tested negative during the testing on . . . . . A progress note dated . . . . . documented Resident #8 was sent to hospital due to . . . , and not eating or drinking. The resident tested positive at the hospital on . . . . . . H) Resident #9 who resided on the Gardenia unit, tested negative during the . . . testing on . A progress note dated documented Resident #9 was sent to the hospital due to being pale, , having a decreased . . . . . , and . . . . . The resident tested positive on . and , on . . . . . . I) Resident #10 who resided on the Azalea unit, tested negative during the . . . testing on . A progress note dated documented Resident #10 was sent to the hospital related to a low saturation and	CZ830		

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CZ830	Continued From page 4 . The resident tested positive at the hospital on . J) Resident #11 who resided on the Orchid unit, tested negative during the testing on . A progress note dated documented Resident #11 complained of , had an saturation level of 88% while on 2 liters of . Resident #11 has a history of ( ) with fluid build up. Resident #11 tested positive at the hospital on . Additional COVID-19 testing for all residents and staff from the Azalea unit, the unit where the majority of positive results were identified with the initial testing, was completed by an outside laboratory on with the following residents reported as positive on : K) Resident #12 who resided on the Azalea unit, tested negative during the testing on . Positive COVID-19 results were identified with the second round of testing. A progress note dated documented Resident #12 was sent to the hospital due to and low saturation. Resident #12 , on . L) Resident #13 who resided on the Azalea unit, tested negative during the testing on . Positive COVID-19 results were identified with the second round of testing. A progress note dated documented Resident #13 was sent out to the hospital. M) Resident #14 who resided on the Azalea unit, tested negative during the testing on . Positive COVID-19 results were identified with the second round of testing. A progress note dated documented Resident #14 had decreased saturation	CZ830		

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CZ830	Continued From page 5 levels and was sent to the hospital. N) Resident #15 who resided on the Azalea unit, tested negative during the testing on . Positive COVID-19 results were identified with the second round of testing. A progress note dated revealed Resident #15 was sent out to the hospital. O) Resident #1 who resided on the Azalea unit, tested negative during the testing on . Resident #1 was admitted to the ALF under Hospice services on , and , at the ALF on . The DOH reported on Resident #1 was positive for the COVID-19 . The Medical Examiner's report documented the primary cause of as , with the secondary as the COVID-19 . Review of COVID-19 testing results revealed the following positive staff: A) Staff A, a Resident Assistant ( ) who worked primarily in the ALF, was tested on with positive results reported to the ALF on by the DOH. B) Staff B, a Dining Room Server, was tested on with positive results reported to the ALF on by the DOH. C) Staff C, a Resident Assistant who worked primarily in the Azalea unit, was tested on with positive results reported to the ALF on by the DOH. D) Staff D, a Housekeeper, was tested on with positive results reported to the ALF on by the DOH. E) Staff E, a Resident Assistant who worked in the Azalea unit and the Transition unit, was tested on with positive results reported to the ALF on by the DOH.	CZ830		

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CZ830	Continued From page 6 F) Staff F, a Resident Assistant who worked in the Transition unit and the ALF, was tested on [redacted] with positive results reported to the ALF on [redacted] by the DOH. G) Staff G, a Dining Room Server, was tested on [redacted] with positive results reported to the ALF on [redacted] by the DOH. H) Staff H, a Resident Assistant who worked primarily in the Azalea unit, tested positive with the second round of testing completed on [redacted] and reported by the outside laboratory on [redacted]. I) Staff I, a Licensed Practical Nurse (LPN) who worked primarily in the Azalea unit, called off work with complaints of a [redacted]. The LPN obtained testing on her own. A report provided by the DOH documented positive results as of [redacted]. The COVID-19 tests results and progress notes revealed 15 positive residents, 5 of whom had [redacted], and 9 positive staff. All 15 positive residents had either been discharged ([redacted]) or transferred out to the hospital. Review of the current Daily Census Report dated [redacted] documented six of the positive residents were currently out of the ALF. Review of the current ESS information for [redacted] revealed the following: Number of former residents (discharged or transferred) who tested positive for COVID-19 was documented as 1 on [redacted] and zero on both [redacted] and [redacted]. Number of staff who have tested positive for COVID-19 was documented as zero on all three days. Review of the ESS instructions to providers documents the following:	CZ830		

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CZ830	Continued From page 7 For the question related to the number of former residents (discharged or transferred) who tested positive for COVID-19, the facility is instructed to enter the total number of COVID-19 positive residents who have been either temporarily transferred or permanently discharged. For the question related to the number of staff who have tested positive for COVID-19, the facility is instructed to enter the number of current employees that have a positive test result for COVID-19. For employees that have had multiple tests, answer question based on the most recent test result. During an interview on [redacted] at 11:07 AM, the Executive Director confirmed she was responsible for entering the ESS information on a daily basis. The Executive Director voiced [redacted] with the data to be entered, unsure if it was a daily number or total number. The Executive Director stated she spoke with someone in Tallahassee for clarification twice. The Executive Director was shown the ESS Long Term Care Facilities Additional Information instruction sheet for providers that includes each question along with the description of the data to be entered. The Executive Director stated she had not seen those instructions, but agreed that the data she had entered was not accurate as it did not include the total number of positive residents and staff in the appropriate data area. Class III	CZ830		