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 _____	05/10/2021

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 Unannounced Licensure Complaint (#2021006335), Focused Control and Generator Assessment surveys were conducted at Courtyard Gardens Senior Living on through and . The facility had a deficiency identified related to the Licensure Complaint suvey (#2021006335).	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain general awareness of the resident's whereabouts, contact family if resident exhibits significant change and maintaining a written record, updated as needed of any significant changes, for 2 of 4 sampled residents (Resident #1 and Resident # 2). The findings included: Review of the facility policy entitled, Policy and	A 025		

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A 025	Continued From page 2 Procedure Resident Observation Log dated , revealed the following: It is required that all facility staff shall exercise their responsibility, consistent with their professional qualifications, to observe residents, to document observations on the appropriate resident's records and to report the observation to the resident's health care provider. 1. Residents are observed daily by staff members. 2. The Resident Observation Log is updated based on occurrences directly or indirectly observed by the staff, reported by the resident or his/her representative. 3. The Administrator or other management personnel and authorized direct care staff are to make written statements directly on the Observation log. Review of the facility's policy entitled, incident report Procedures, dated revealed the following: 1. All incidents must be described in detail-exactly what happened, what injury or suspected injury occurred, actions taken regarding this possible injury and who was notified and the date and the time and what anyone notified said. 2. Who examined the resident, what did they see. Was there any first aid given and specifically, what and by whom, if an instruction was given regarding the situation. 3. All portions of this need to be recorded in notes made in the resident's record as well as on	A 025		

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A 025	Continued From page 3 the incident report/even the log form. No one leave at the end of a shift until this is done. 4. When an incident occurs, there must be a full investigation by the manager to ensure that it is not repeated, and that staff have properly carried out their responsibilities. Review of the facility's Adverse incident report revealed that Resident # 1 was involved in a possible . . . . misconduct with Resident # 2 on . The , incident came to light when Resident # 2 was found in Resident # 1's room with her bra strap off of her . During an interview with the Administrator on at 9:45 AM, he revealed Resident # 2 was found in Resident # 1 room on . The surveyor asked for the incident report and/or documentation regarding the investigation of the incident. The Administrator provided the surveyor with random investigation questionnaire forms completed by various staff with no dates; no follow-up to the responses and/or an opportunity for staff to explain the actual events surrounding Resiclen t#1 and #2. However, he was not able to provide documentation reflecting an internal investigation regarding Resident # 1 and Resident # 2. He provided the surveyor with the 1 - day adverse report with an incident date of and Preliminary submission date of . . . . . During confidential staff interviews conducted on through between 9:00 AM and 4:00 PM the following was revealed regarding Resident # 1. a) Resident # 1 was extremely aggressive towards everyone. The resident was very controlling of Resident # 2 and staff would have a	A 025		

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A 025	Continued From page 4 hard time redirecting this resident. b) Resident # 1 was also verbally aggressive and exhibited inappropriate behavior. c) Resident #1 was found alone in a room with Resident #2 on various occasions. Record review of Resident # 1 Health Assessment documented he suffered from [illegible] and poor memory loss. Review of the Progress Notes from [illegible] to [illegible], revealed the following: a) [illegible] - Resident # 1 noted increased inappropriate gestures to staff. b) [illegible] - Resident # 1 seen by psychiatrist regarding new medication orders for increased agitation. c) [illegible] - Resident # 1 presenting extreme [illegible], and aggression. Constantly attempting elopement and acts aggressive towards staff. Record review of Resident # 2 Health Assessment documented she suffered from [illegible] and [illegible]. Review of progress notes from [illegible] to [illegible], revealed the following: a) [illegible] - Resident # 2 Health Assessment documented she suffered from [illegible] and [illegible]. Review of the Progress Notes from [illegible] to [illegible], revealed the following: b) [illegible] - Resident # 2 was seen by psychiatrist for new medication order for [illegible].	A 025		

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A 025	Continued From page 5 c) - Resident # 2 was seen by psychiatrist for increased medication order due to swings and . A family interview was conducted with Resident # 1's daughter on at 7:47 AM. She stated that they moved her father out of his room to another room twice and never told her. Her father told her he slept in the hallway because he was locked out of his room. She knew that there were some things going on with her father regarding him and other women "shenanigans". She stated he was unsupervised. The facility never mentioned anything until she mentioned something. She kept asking for a care meeting and they would never give it to her. She was told that her father was being punished because the facility had put him in a room by himself. The local Police Department got involved and her father was listed as the victim. When she would visit without notice they would not let her in to see her father. The facility is extremely rude. She stated that anytime that she had an issue or complaint they would just say that is not their fault. About two months ago it was about 8:00 PM, she went unannounced to visit her father. A woman answered the door and said I could not see my father's room. It was an awful experience. She stated that her father was crying every day. He was at the facility for 5 months. She stated that her father said that they were yelling at him and they would lock him out of his room. They had nothing for him to do all day. On at 12:35 PM a conference call was conducted with the Administrator, Assisted Living Facility (ALF) Supervisor, and the two surveyors that conducted the survey. The Administrator stated that late around is when	A 025		

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A 025	Continued From page 6	A 025		

he started to learn that Resident # 2 was in Resident # 1's room. A staff member had informed a former Director of Nursing (DON) of this information. The DON is no longer at the facility, his last day was . Resident # 1 and Resident # 2 started off by holding . Resident # 1 began to become more possessive of Resident # 2. In the beginning Resident # 2 was less aggressive with Resident # 1, but the staff knew something was going on. Resident # 1 and Resident # 2 were seeking out each other. He stated that he was informed that on Resident # 2 and Resident # 1 were in Resident # 1's room. Resident # 1 and Resident # 2 resided within the same wing around the corner from each other before Resident #1 was relocated.

The Administrator stated at 12:50 PM on , that the protocol is to report any incidents to Management. He stated there is nothing wrong with the resident being friends. The staff was informed to keep an , out if Resident # 1 and Resident # 2 were getting too friendly. The Administrator stated that the facility has cross over meetings in which their caregivers get together and go over what is happening in the community. The former DON was the first person that was informed of the incident between Resident # 1 and Resident # 2. The Administrator stated that it was hard to deal with Resident # 1. Resident # 1 was reassessed for continued residency by our psychiatrist but not his by health care provider. The cameras in the wings are used to keep an , on the community and things that happen for the owners. The Administrator stated that he only uses the cameras to keep an , on the community. He stated that he does not have access to go and look at the previous footage on the camera. He also stated he didn't review any footage regarding incidents for

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A 025	Continued From page 7	A 025		

Resident #1 and #2. He stated only the owners have access to the camera's footage from . . . . . to . . . . . . The camera's footage only keeps for two weeks. At this time, the questionnaire forms were discussed with the Administrator again. He confirmed that he had not followed-up further regarding any responses and/or spoke directly with staff regarding the actual details for the events for Resident #1 and #2 . He also didn't have any documentation reflecting steps taken to prevent the reoccurrence of the behavior of Resident #1 and/or Resident #1 and #2.

According to the Administrator, the facility's Community Liaison (move in coordinator) observed Resident # 2 in Resident # 1's room on . . . . . He informed management, but it was not investigated. All staff that had knowledge of the incident were not interviewed. When Resident # 2 was found in Resident # 1's room, she was not sent out for further evaluation and assessment. The Administrator stated that there was no sign of distress. There is one or more occasions that they were found with inappropriate behaviors. Resident # 1 came into the facility before the Administrator started working as the facility Administrator. The Administration change took place on . . . . . Before he was the Administrator , he was hired as the Activities Director in . . . . . The prior Administrator left no documentation regarding Resident # 1 and Resident # 2's behavior behind.

The Administrator acknowledged on . . . . . at 1:20 PM , that Resident #1 had started to exhibit signficant behavior changes. He was unable to provide any documentation reflecting steps the facility implemented to appropriately supervise the residents and to prevent reoccurrence of

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A 025	Continued From page 8 noted behaviors. The facility also failed to provide evidence of documentation of the signficant behavior changes and appropriate notification. Class III	A 025		