

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/23/2021
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA		STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(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 A revisit for a Change of Ownership survey and two compliant investigations (complaints numbered 2020019654 & #2020017280) was conducted on through- at Courtyard Plaza. Deficiencies were identified at the time of the survey.	{A 000}		
A 025 SS=G	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 supervision as appropriate for each resident, including the following:	A 025		

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

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

15520 NW 2 AVENUE

NORTH MIAMI BEACH, FL 33160

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A 025	Continued From page 1 (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, record review and interview, the facility failed to provide adequate supervision and to maintain a general awareness for one out of thirty-eight sampled residents' whereabouts (Resident#38). Resident#38 was _____ for roaming into another resident's room without permission which resulted in Resident#38 suffering a _____ bone and two black _____ Findings Included: On _____ at 10:30am, observed Resident#38	A 025		

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A 025	Continued From page 2 leaving his bedroom. The resident was observed to have two black , and scratches on the area and area of . In an interview with Staff M (Director of Social Service) on at 2:15pm she stated Resident#39 had Resident#38 on for entering his room without permission. The assault resulted in Resident#38 having two black , and bone. A review of the facility's adverse incident report dated on revealed "At 10:30am, Resident #41 called for help because his roommate Resident#39 was hitting Resident#38 more than 4 times in the . Resident#38 was in the . Staff S and Staff T was working during the time go the incident. 911 was called, Resident#38 was transported to the hospital and Resident#39 was . The resident's doctor and guardian were notified of incident". A review of Resident#38's health assessment dated on showed the resident had a medical history and diagnosis of legally , Right , Unspecified , with behavioral disturbances. It stated the resident required assistance with self- administration of medication and supervision with toileting, self-care (Grooming), and toileting. In an interview with Staff T (caregiver) on at 11:30am, she stated Resident#38 was because he entered into Resident#39's room without permission. She further stated he roams from room to room because he is and freely ambulates in	A 025			

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A 025	Continued From page 3 wheelchair. She stated, "He roams, we put him in the patio area or where he needs to go however, he constantly moves around. Even if he had a private duty aide, he would still roam". In an interview with Staff S (caregiver) on at 11:09am she stated as a preventative method for Resident#38 blindly roaming into rooms, Staff would supervise him while he is out in the courtyard area and will guide him to patio or wherever he needs to go, if he roams somewhere, he should not. In an interview with the Administrator on at 4:20pm stated as a preventive measure for Resident#38 roaming blindly into other resident's room, he hired extra staff to supervise the residents in the courtyard patio area while another staff tend to the residents, after on Class II	A 025			
A 027 SS=D	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making and remind residents about scheduled for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation.	A 027			

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A 027	Continued From page 4 (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that one out of thirty-eight sampled residents (Resident#38) received medical care when needed. Resident#38 suffered scratches on his due to repeatedly running into doors and received no medical care for the injury. The resident also had an untreated . Findings Included: On . at 10:30 am, observed Resident#38 leaving his bedroom. The resident was observed with two black . and scratches on the . area and . area of . Gauze was wrapped around his right . On . at 11:10 am, observation revealed a and scars on Resident#38's right . On . at 11:35 am, Staff M stated, " He's wearing a long sleeve, so he doesn't hit those, his scars". A review of Resident#38's health assessment dated on . showed the resident had a medical history and diagnosis of legally , Right ., Unspecified . with behavioral disturbances. It stated the resident required assistance with self- administration of medication and supervision with toileting, self-care (Grooming), and toileting.	A 027			

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A 027	Continued From page 5 In a interview on at 10:57 am with Staff N regarding scratches on Resident#38's arm, he stated Resident#38 had scratches and from hitting himself while entering and leaving rooms because he's He was not sure how the black occurred. In an interview with Staff M (Director of Social Service) on at 2:15 pm stated Resident#39 had Resident#38 on for entering his room without permission. The assault had resulted on Resident#38 having two black and bone. When asked how the scratches occurred, she stated Resident#38 received scratches by bumping into the doors due to his vision She stated Resident#38's doctor was informed of scratches however the doctor didn't give any orders for treatment plan for his She also stated she wrapped gauze around Resident#38's to prevent him from scratching his while his scratches were healing. A review of Resident#38's progress notes showed no documentation that a medical provider was informed of scratches or the or that medical attention was sought. Class III	A 027			
(A 030) SS=J	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	(A 030)			

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{A 030}	Continued From page 6 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 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	{A 030}			

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{A 030}	Continued From page 7 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 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 030}			

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{A 030}	Continued From page 8 (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. (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	{A 030}			

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{A 030}	Continued From page 9 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 relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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	{A 030}			

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{A 030}	Continued From page 10 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 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.-	{A 030}		

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{A 030}	Continued From page 11 (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. (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: 0030 Based on observation, record review, and interview the facility failed to honor the residents' rights to live in an environment free from _____ and neglect for two out of thirty- eight sampled residents (Resident#38 and #40). Resident#39 physically assaulted Resident#40 before being jailed and hospitalized. One month and four days after his incarceration and hospitalization on a locked crisis unit at the hospital, the facility allowed Resident#39 to return to the facility without implementing any tangible interventions. Three months later, Resident#39 _____ Resident#38 for entering in his room without permission. Resident#38 suffered a _____, two black _____, and scratches. Findings: Incident #1	{A 030}			

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{A 030}	Continued From page 12 A review of the facility's adverse incident dated on _____ revealed, "At 9:23am on _____ Resident#39 allegedly fought with Resident#40 in the Resident Dining Room. Kitchen servers stated he heard Resident#39 screaming at Resident#40 stated, "You are sitting in my seat". Kitchen staff stated he hit Resident#40 in the _____ with his right _____. Upon further investigation, the Administrator observed _____ from _____ and _____. Resident#40's _____ was observed to be chipped. Resident#39 was _____ and charged with a felony for battery. A review of the Resident#39's health assessment dated on _____ showed Resident#39 had a medical history or diagnosis of Unspecified _____, major _____, history of _____ substances _____ of (_____), _____, and history of _____ from assault. It stated the resident was required follow up _____ services and required assistance with self- administration with medication and supervision with self- grooming. A review of Resident#40's hospital's record showed on _____ Resident#40 was transferred to the hospital due to an assault to the _____ and was released later that day. He suffered two black _____ and a chipped _____. A review of Resident #40's health assessment dated _____ showed the resident had a medical history or diagnosis of _____, Unspecified, Lymphoma, and Unspecified site. The health assessment stated the resident required assistance with self-Administration of medication and supervision with bathing, _____, toileting, and transferring.	{A 030}		

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{A 030}	Continued From page 13 A review of the Resident#40's progress notes dated on showed there was no documentation that the assault occurred. In an interview with Resident#39's guardian on at 4:05 pm, she stated she asked the administrator if it was okay for Resident#39 to return to the facility after being incarcerated and treatment. She confirmed that the administrator allowed Resident#39 to come to the facility. She stated Resident#39 returned to the facility on . In an interview with the Administrator on at 3:15 pm, he stated Resident#39's doctor stated he was able to return and as preventive caution, he had instructed Staff L to call 911 to have Resident#39 and receive treatment. Resident#40 was transferred to the hospital for further observation. He also stated Resident#40 was moved to another room with another resident after Resident#40 returned from the hospital. In an interview with Staff N (caregiver) on at 11:25 am, he stated regarding Resident #39, "He is a quiet guy, but the small things make him mad. For example, if he does not get his cigarettes, someone sits in his seat, or goes in his room, he will get mad and aggressive". In an interview with Staff K (caregiver) on at 11:30 am, she stated Resident#39 was aggressive to everyone (Staff and Residents). In an interview with Staff H and N (Both medication technicians) on 2:15 pm, they agreed regarding Resident #39 that he had always been like that but if he did get aggressive,	{A 030}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/23/2021
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
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{A 030}	Continued From page 14 staff were able to calm him down. A review of the facility's bill of rights revealed the facility agreed to ensure all residents would live in a safe and decent home free from _____ and neglect. The policies further stated that the facility would discharge any resident or representative who physically assaulted a resident. However, the facility allowed Resident#39 to return to the facility. Incident #2 On _____ at 10:30 am, observation revealed Resident#38 leaving his bedroom. The resident was observed to have two black _____ and scratches on the _____ area and _____ area of _____. In an interview with Staff N on _____ at 10:35 am he stated, "Resident had scratches on his _____ because he bumps into doors and walls due to being _____." On _____ at 11:05 am, Resident#38 stated, "He hit me!". He was unable to state who hit him or how he was hit. In an interview with Staff M (Director of Social Service) on _____ at 2:15 pm stated Resident#39 had _____ Resident#38 on _____. The assault had resulted on Resident#38 having two black _____. When asked how the scratches occurred, she and other several staff stated Resident#38 received scratches by bumping into doors due to his visual _____. A review of the facility's adverse incident report dated on _____ revealed "At 10:30 am,	{A 030}			

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{A 030}	Continued From page 15 Resident #41 called for help because his roommate Resident#39 was hitting Resident#38 more than 4 times in the Resident#38 was in the Staff L and Staff K was working during the time go the incident. 911 was called, Resident#38 was transported to the hospital and Resident#40 was The resident's doctor and guardian were notified of incident". A review of Resident#39's progress notes dated revealed," Resident#39 was transported to jail via 911 due to an assault towards another resident (Resident#40)". A review of Resident#38's health assessment dated on showed the resident had a medical history and diagnosis of legally Right , Unspecified with behavioral disturbances. It stated the resident required assistance with self- administration of medication and supervision with toileting, self-care (Grooming), and toileting. A review of Resident#38's hospital record dated on revealed the resident was transferred to the hospital due to assault to the It revealed that Resident#38 suffered a bone with a right medial orbital wall In an interview with Staff L (caregiver) on at 10:56 am, she stated she was the manager on duty at the time of the incident. She stated she heard Resident#41 call out for help. She immediately started to to the room and called Staff K (caregiver) for assistance. Upon arrival, Staff K had arrived first and kept the	{A 030}			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

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{A 030}	Continued From page 16 resident separated. Staff K informed her Resident#39 had hit Resident#38 for coming into his room without permission. After the , she stated "Resident#38 had scratches, two black and a bloody . She stated she called the Administrator, was instructed to call 911, 911 arrived, Resident#39 was , and Resident#38 was transferred to the hospital". In an interview with Staff K on at 11:21 am, she stated that Resident#41 was a witness. Staff K stated that Resident #41 saw the incident and flagged Staff L. Staff K stated she opened the door and Resident#39 showed her his fists that were covered in , then walked into the courtyard area. Resident #39 told her, regarding Resident #38, that he "got him good," then left his room to the courtyard patio. Staff K stated after the , Resident#38 observed to have two black and a bloody . Staff L and Staff E tended to Resident#38 after the . In a further interview with Staff K on at 11:30 am, she stated Resident#38 roamed from room to room because he is and mobile in wheelchair. She stated, "He roams, we put him in the patio area or where he needs to go however, he constantly moves around to somewhere else. Even if he had a private duty aide, he would still roam". In an interview with Staff L (Weekend Manager) on at 11:09 am she stated as a preventative measure for Resident#38 blindly roaming into rooms, Staff would supervise him while he is out in the courtyard area and will guide him to patio or wherever he needs to go, if he roams somewhere, he should not. In an interview with the Administrator on	{A 030}		

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{A 030}	Continued From page 17 at 1:15 pm, he stated Resident#39 was not allowed to come to the facility in order to keep all other residents safe from his The administrator was unable to clarify why Resident #39 was allowed after assaulting the first person (Resident #40). Class I	{A 030}		