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
	AL11953671	A. BUILDING: _____ B. WING _____	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT LAKES	280 SIERRA DRIVE NORTH MIAMI BEACH, FL 33179

(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 AMENDED A Change of Ownership and a Complaint Investigation (Complaints #2021001948 and 2021005856) were conducted at Grand Court Lakes on to . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=L	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		

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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 as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for seven out of 24 sampled residents (Resident # 2, #17, #18, #20, #22, #23, and #25). Resident # 17 overdosed at the facility twice within four days and sustained a right after falling. Resident #25 was found unresponsive in his room and sustained multiple . Resident #2 sustained a , after falling when pushed by another resident in the memory care unit.	A 025		

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A 025	Continued From page 2 Resident # 18 sustained a after a . Resident # 23 sustained throughout the body, and Resident #20, and #22 both suffered a hematoma to the after falling. Findings include: 1) A review of Resident #17's progress notes dated showed on , "resident found in bed unresponsive, [, ,] initiated, 911 was notified. Resident was transported to the hospital". A review of Resident #17's hospital records dated showed, "patient with a past medical history of , , heroin , [ST-Segment Elevation ,] [presents to the Emergency Department for overdose. She arrives at the Emergency Department via ambulance. According to [Emergency Medical Services], staff found her unresponsive. states that she was apneic (temporary cessation of breathing), pinpoint pupils, Glasgow Scale (GSC) of 3. The GCS maximum score is 15 (normal) and a minimum score of 3 (deep). The resident was administered , gave 2 mg [milligrams] of [ ] Narcan, and the patient woke up. On arrival to the ED, she had a GCS of 15. She did not want to talk about what happened. Per chart review, she has been here for , overdose. stated that they received a call from the facility for her overdose". On at 12:47 PM, the Administrator stated, that "[Resident #17] left the facility on with another resident earlier that day	A 025		

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A 025	Continued From page 3 to go to [store] but went somewhere else. Resident #17 was found [illegible] in Resident #23's bed. Resident #17 refused to tell if she took anything. In an interview with Resident #23 on [illegible] at 2:45 PM, the resident stated Resident #17 and her left the facility on [illegible]. They were supposed to go to [store], but instead, they went to Overtown. She stated that Resident #17 went to the city to get heroin. After returning to the facility, Resident #17 went to her bathroom to take it. When she came out of the bathroom, Resident #17 passed out on her bed. She then called for help. A review of Resident #17's health assessment (AHCA form 1823) dated [illegible] showed medical diagnoses and a history of [illegible], unspecified [illegible] of the [illegible], unspecified [illegible], and [illegible] ([illegible]). Resident #17 has no precautions and is independent with ambulation, bathing, [illegible], eating, self-care, toileting, and transferring and needed assistance with self-administration of medication. A review of Resident #17's progress notes dated [illegible] at 1:45 PM showed, "resident is [illegible] and has AMS ([illegible]), resident started to decline and was very slow to respond. The resident has Narcan due to similar symptoms in the past. The first treatment of Narcan was given nasally, and the resident continues to be [illegible] and unable to respond. The resident was brought to Nursing Office for continuous [illegible] saturation. Resident saturating between 83% to 87%. The second	A 025		

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A 025	Continued From page 4	A 025		

treatment was given. After 15 minutes, the resident became more alert and orientated. Non-emergency called for evaluation."

During an interview on at 3:20 PM, the Director of Nursing stated that Resident #17 overdosed twice in the facility on and . Regarding both incidents, the nurse stated that she did not know which substance the resident took. She only knows it was an " , " since the resident responded to Narcan.

A review of the resident record found no documentation of actions by the facility to ensure that the resident received medical care related to the overdose. There was also no documentation of increased resident wellness checks to ensure that the resident was not suffering overdose.

A review of the agency's adverse incident database showed that no incident reports were filed for Resident #17's drug overdoses.

A review of the facility's incident report dated showed, "upon rounds [Resident #17] was found sitting in the bathroom floor. She stated she hit her . Redness was noted on the forehead. She stated she lost her balance while using the restroom. She stated her forehead was in , . The resident was offered to go to the hospital, and she agreed. "

A review of Resident #17's hospital records dated showed, the "patient presenting to the Emergency Department complaining of to the left forehead due to a . She stated that she went to the bathroom and then ."

A review of a second facility incident report dated at 2:30 AM showed, "Upon rounds

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A 025	Continued From page 5 [Resident #17] was found in common area sitting on the floor, she stated she and lost her balance. A small was noted on the right ; she complained of , on the arm. She offered to go to the hospital for further evaluation. She agreed." A review of Resident #17's hospital record dated showed a 'History of Present Illness' that showed "Female who presented to the emergency room with complains of right , . The patient had a mechanical at the ALF [Assisted Living Facility] where she lives. The patient reports having at that facility. Seen and examined in her room, she reports , in her right and right . [Resident #17] demonstrated surgical of the right , with impaction and , angulation." A review of the agency's adverse incident database showed Resident #17's and injury was not reported. Further review showed there were 5 facility incidents reports found related to Resident #17. A facility incident report dated at 5:20 AM showed, regarding Resident #17, "upon rounds resident stated while she was dressed to get ready for an , , she slipped and and lost her balance. A small tear was noted on the right ; she is complaining of , on the arm. She was offered to go to the hospital for further evaluation. She agreed." A review of Resident #17's hospital record dated record showed, "patient with a past medical history of recent (right arm in a sling), , , previous history of drug-seeking behavior, , ,	A 025		

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A 025	Continued From page 6 , previous , and who present from ALF following ground-level ." A review of a facility incident report dated at 5:00 AM showed, "[Resident #17] stated she hit her while bending down against nightstand. She states she has no , at this time. Cut noted on the right of the forehead. She was offered to go to the hospital for further evaluation but refused." A review of Resident #17's record showed the resident signed a refusal of treatment consent form stating that the resident was executing her rights to refuse treatment and was fully aware of the risks of such things. Further review showed a court record dated , , which documented that the resident was a ward of the Guardianship Program. The program was given guardianship of Resident #17's person and estate, and she was therefore deemed to lack capacity to refuse medical treatment without the guardian's consent. In an interview on at 10:30 AM, Resident #17 stated, "I three times. The first two times, I refused to go to the hospital. I told them no. They asked me to go, but I didn't want to go to the emergency hustle; you know, wasting time in the emergency room for nothing. I signed the paper that I did not want to go to the hospital. I signed it the first two times." In an interview with the caseworker from the Guardianship Program on at 9:49 AM, she stated, "residents under the Guardianship Program are unable to make medical decisions. We have all rights regarding medical decisions, not the resident. They should	A 025		

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A 025	Continued From page 7 call us if a resident refuses treatment. The residents under guardianship program cannot consent or sign any medical documents." A review of a facility incident report dated at 5:15 AM showed "[Resident #17] was observed on the floor in a sitting position at 5:15 AM. Was alert, oriented x3. She stated she was going to the bathroom and had a small cut-over right . She refused to go to the hospital. The resident stated no at this time." A review of Resident #17's health care provider notes dated showed, "patient seen for a follow-up visit at ALF for post- . The patient refused hospitalization. The patient appears no apparent distress, reports episodes of . The patient has her right arm in a sling due to a . The patient is homebound due to , , etc. The patient cannot complete ADLs [Activities of Daily Living] independently and cannot attend , , outside of the facility independently. The patient requires assistance with ADL completion." Further review of Resident #17's records showed no documentation of an updated health assessment/1823 since and after the resident's . On at 10:22 AM, the Director of Nursing stated that to prevent Resident #17 from continuing to , the facility provided proper footwear, education and aided with ADL such as assistance with shower. Observation on at 10:20 AM showed no phone nor call light in Resident #17's room. On at 10:40 AM, Resident #17 stated,	A 025		

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A 025	Continued From page 8 "I don't have a cell phone. So I don't have any way to contact the staff if I need anything. The staff comes here very often, like every 45 minutes or 1 hour. So if I need help, I guess I have to go downstairs or wait until they come up here." In an interview on . . . . . at 12:02 PM, the Director of Nursing stated, "Staff checks on residents every two hours." When asked how the residents contact the staff if they have no cellphone and were on the floor, the Director of Nursing stated, "If they are on the floor, they would have to wait until someone comes in to see them." 2) Review of the facility's incident report dated . . . . . showed, "[Resident #25] was observed down in his wheelchair by his bedroom door at 3:17 AM. [Resident #25] was unresponsive, 911 was called he was taken to [local hospital]. Sister was contacted by leaving a message and his PCP (primary care physician) also was contacted." Review of Resident #25's progress notes dated showed, "[Resident #25] has returned from hospital tonight at 10:45 PM." However, there was no documentation of the incident. A review of Resident #25's progress notes dated . . . . . showed, "resident was observed on the floor. Stated he was transferring to the wheelchair and . . He stated that he is okay not having any , don't need to go to the hospital he said he refused." A review of Resident #25's progress notes dated showed, "resident has small on right , no noted. Resident educated on safety precautions with wheelchair."	A 025		

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A 025	Continued From page 9 On at 8:30 AM, Resident #25 stated "I in the bathroom and hit my and have a on my that the nurse is taking care of it." In an interview with Resident #25's sister on at 9:27 AM, she stated the resident called her to let her know that he on at 1:23 AM between the sink and toilet and cut himself on the and . She further stated that the facility did not contact her until the next day of Resident #25's . A review of the facility's records showed no incident report for Resident #25 regarding . On at 11:15 AM, when asked for the facility's incident report for Resident #25's , the administrator stated, "No, there is no incident report for his ." The administrator also stated that no additional interventions were implemented. A review of Resident #25's health assessment, Form 1823 completed on indicated the resident had a medical history and diagnosis of , history , sleep , ( ), CAS ( ), history of , (prostatic hyperplasia), ( ), ASHD ( ), . The resident needed supervision with bathing and was independent with the rest of the activities of daily living. 3) A review of the adverse incident report filed on showed that on , Resident	A 025		

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A	Continued From page 10	A 025		

#2 was found sitting in the hallway of the memory care unit by staff doing rounds. Resident #2 stated Resident #21 pushed her. When staff interviewed Resident #21, she said that Resident #2 was always trying to into her room without knocking or permission, but she denied pushing the resident. Staff contacted 911, and Resident #2 was transferred to the hospital.

A review of Resident #2's progress notes dated showed "resident found upon rounds on the hallway floor in memory care in a sitting position. The resident asked why she is sitting on the floor. The resident stated another resident pushed her. Upon assessment, the resident was not able to get up. 911 called resident transported to [hospital]."

A review of Resident #2's health assessment Form 1823 dated showed medical diagnoses and a history of , with behavioral disturbance, valve , left , and . The resident had no precautions and was independent with ambulation, bathing, eating, toileting, and transferring and needed supervision with grooming.

A review of the hospital records dated showed, a 'History of Present Illness' of "patient is reported as being ambulatory and moderately independent in the nursing home, despite needing assistance with Activities of Daily Living (ADL's) due to her advanced . The patient apparently had a trip and . Unclear if it was witnessed. They state that there was significant when they attempted to mobilize her, with the almost entirely in the left . They also note that they found the patient to have

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A 025	Continued From page 11 a left , was externally rotated and foreshortened." Further review showed that Resident #2 had a . . . . . of the left , . In an interview on . . . . . at 3:57 PM, Staff D (Med Tech) stated, "I remember that day I was working. It was about 5:15 PM. I was sitting with an agitated resident in the dining room, trying to calm her down. I heard somebody scream. I did see Resident #2 on the floor, but I did not want to leave the resident by herself because she was already agitated. Another staff who told me the resident told her that she was passing by going to her room, and another resident pushed her to the floor. " On at 10:20 AM, Staff E (caregiver) stated she was off the day Resident #2 but confirmed that the resident was always . . . . . and walking into other residents' room thinking it was her own. During an interview on . . . . . at 12:32 PM, when asked about the incident with Resident #2, the Director of Nursing (DON) stated, "Another resident in the memory care pushed her. She had a , injury. Staff saw her sitting on the floor by the door of the resident she claimed pushed her. The staff did not observe the incident. The other resident (Resident #21) stated she pushed her because [Resident #2] keeps knocking and trying to get into her room. We spoke to Resident #21 and educated her that she needed to request assistance from staff when she gets into an argument with residents." 4) A review of the facility's incident report dated showed that "[Resident #18] by the pool area. The resident was observed attempting to sit down and lost her balance. The	A 025		

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A 025	Continued From page 12 resident did not have any redness or , at that time. The resident was offered to go to the hospital, but she refused." A review of Resident #18's record showed the resident signed a refusal of treatment consent form stating that the resident was executing her rights to refuse treatment and was fully aware of the risks of such things. Further review showed that the resident was under the Guardianship Program. In an interview with the caseworker from the Guardianship Program on at 9:49 AM, she stated, "residents under the Guardianship Program are unable to make medical decisions. We have all rights regarding medical decisions, not the resident. They should call us if a resident refuses treatment. The residents under guardianship program cannot consent or sign any medical documents." A review of Resident #18's health assessment Form 1823 dated showed medical diagnoses and a history of Advanced , type 2, , , , toothache, , , and unsteady gait. Resident #18 needed precautions and supervision with bathing and . A review of Resident #18's progress notes showed that the resident was transferred to the hospital on . A review of hospital records dated showed a 'History of Present Illness' showing "[Resident #18] was sent in from nursing home for evaluation after she sustained a yesterday	A 025		

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A 025	Continued From page 13 and been complaining of low . . . , . . since then. The patient complains that the , radiates from the . . . . . area to the . . . . . , area. The occurrence was one day prior to arrival." The resident was diagnosed with an L2 acute . . , . . endplate . A review of the agency's adverse incident database showed Resident #18's . . and injury was not reported. During an interview on at 3:38 PM, the Director of Nursing (DON) stated, "we contacted resident's physician all the time and followed their recommendations." A review of Resident #18's progress notes showed no documentation of physician recommendations to prevent the reoccurrence of . In an interview on at 3:39 PM, when asked why documentation was not in the resident's progress notes, the Director of Nursing stated, "We should document physician recommendations, but it was not there." 5) A review of the facility's incident report dated . . . . . showed at 9:28 AM, "[Resident #20] was observed on the bathroom floor. Alert and oriented x 3. The resident stated she got off the toilet to transport to a wheelchair and on her bottom. The resident hit her . . . on the door. The resident has a bump at the of her . . . . ." A review of Resident #20's progress notes dated showed, "Resident was observed on the bathroom floor alert and oriented x3. The resident stated that she got off the toilet to be	A 025		

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A 025	Continued From page 14 transported to a wheelchair, slipped away, and on her . Resident hit her on door jam of which a bump is at the of her . The resident was transported to the hospital emergency room via ambulance." A review of Resident #20's hospital records dated showed "patient states she was getting off the toilet, reaching for her wheelchair, when she slipped and , falling onto her side, hitting the of her , patient endorses , in the , , , vertex. The patient also endorses right- as well as , in her , , low , sides, and left ." A review of Resident #20's health assessment dated showed medical diagnoses and a history of post-COVID-19, , , , , mobility, , and . The resident had no precautions and needed assistance with ambulation, bathing, , self-care, toileting, and transferring. Further review of Resident #20's records showed no documentation of an updated health assessment after Resident #20's . During an interview with at 10:26 AM, Resident #20 stated, "I like three times, the last time was last week, but I did not go to the hospital. They asked me, but I refused. I hurt my and . I stayed on the floor for like 2 hours until someone came. I don't have a phone." Observation on at 9:40 AM showed no phone nor call light in Resident #20's room. 6) A review of the facility's incident report dated showed at 2:00 PM, "[Resident #22]	A 025		

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A 025	Continued From page 15 while playing activities on her . The resident got up right away. She stated no , at this time." The staff noted that the resident sustained a . A review of a second facility incident report dated showed at 7:30 AM, "[Resident #22] was found during rounds with a large hematoma on the of her . When asked how she got the injury, the resident stated that she was playing in the corner of her room and noted discomfort noted." The resident was then transferred to the hospital. A review of Resident #22's hospital record dated showed a 'History of Present Illness' of "a patient admitted after a . The patient stated that she slipped and yesterday and had to the left- part of her . She is a poor historian, but she denies any loss of , no palpitations, no , no . The patient is mildly but still oriented to place, person and place." A review of Resident #22's health assessment dated showed medical diagnoses and a history of Type 2, history of , , the potential for further , , major , and . The resident had precautions and needed supervision with bathing, , eating, self-care, toileting, and transferring. 7) A review of the facility's incident report dated showed at 5:40 AM "[Resident #23] observed on the floor, he stated he lost balance when moving from bed to wheelchair." A review of Resident #23's health assessment	A 025		

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A 025	Continued From page 16 dated ..... showed medical diagnoses and a history of acute , injury, acute ..... Type 2, and left below- . The resident had precautions and needed assistance with ambulation, bathing, , self-care, toileting and transferring. A review of a second facility incident report dated showed "[Resident #23] at 10:50 PM in room. CNA (Certified Nurse Assistant) reported that during rounds when they saw [Resident #], he was on the floor. She asked him what happened, he stated he attempted to get up and lost his balance. Resident is currently showing signs of but states no , at this time. Redness noted on . 911 was called, paramedics did further evaluation. Residents remain in facility due to him being stable. " A review of a third facility incident report showed "Upon rounds [Resident #23] was found sitting next to his bed. Resident states he's weak. No redness noted, skin intact. Resident states no , at this time." A review of Resident #23's progress notes dated ..... showed that the resident was sent to the hospital due to him being in , due to his .. A review of the facility's incident report dated showed that "[Resident #23] on the bedroom floor at 2 AM. Resident was found on the floor stated he turned on his bed and off. He stated he wanted to go to the hospital and when 911 came he changed his mind." A review of Resident #23's progress notes	A 025		

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A 025	Continued From page 17 showed no documentation of physician recommendations to prevent the reoccurrence of . . On . . at 3:02 PM, when asked whether the facility assesses its residents for risks, the Director of Nursing stated, "We don't have assessments done for them. We use the health assessment." During an interview on . . . . at 3:18 PM, when asked if the facility has any prevention policies in place, the administrator stated, "No, we don't have any prevention policies in place." In an interview on at 2:00 PM, Staff G, front desk receptionist, stated, "during the time I'm here, the CNA and HHA (Home Health Aide) do 2 hours rounds. Some residents have a cell phone. If they need assistance, they will call me, and I will radio the staff. The residents don't have a phone in their rooms. Not all residents have cell phones. If a person . . and does not have a cell phone, I guess they will have to wait until the staff goes to their room. They used to have a buzzer by the of their beds and in the bathrooms. They removed them sometimes ago." On . . . . . at 12:02 PM, the Director of Nursing (DON) stated that staff conducted two-hour checks on the residents. When asked how residents contact the staff if they have and are on the floor, the DON stated, "If they were on the floor, they would have to wait until staff comes in." Class I	A 025		

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A 027	Continued From page 18	A 027		
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 [illegible] and remind residents about scheduled [illegible] 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. (c) The facility may not require residents to receive services from a [illegible] health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to arrange health care service for four out of 24 sampled residents (# 17, 18, 25 and 26). Finding include: A) In a review of Resident #26 Health Assessment dated [illegible], the assessment showed an alert and orientated x3 (person, place, and time) resident that has the following medical diagnosis and history: [illegible] on [illegible], history of falling, [illegible], left arm [illegible], non- [illegible] regurgitation, [illegible] pectoris, [illegible], complication of [illegible] devise, [illegible], and [illegible].	A 027		

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A 027	Continued From page 19 In an interview with Resident #26 on at 8:05 AM, the resident complaint of area that started a couple of days ago. He stated that the is constant and ranks the at 9 (0-10). He reports that there is no in the area. He stated that he told a staff member about the yesterday ( ), but he was not seen by the nurse. He also stated that he had this type of before, and the physician has ordered . The nursing department was notified of the incident on at approximately 8:30 AM. In an interview of Staff F on at 9:24 AM, Staff F stated that she just finished evaluating Resident #26. As for his prior complain about , she stated, "this is the first time I it". She also stated that during the evaluation, the resident told her that he told a staff member about the yesterday but could not remember the staff member's name. According to Staff F, the staff should have notified the nurse on duty about the residents complain. Finally, Staff F stated that she called the resident's primary care provider and received the following orders: get a analysis (U/A), and the physician will order . A review of the Resident Observation Log on , show no documentation that the resident was seen by the nursing staff on . B) A review of the facility's records and resident records showed 15 residents were under the guardianship program. Further review of the assessment showed Residents #17 and #18	A 027		

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A 027	Continued From page 20 signed in 2 separate occasions refusing medical attention after sustained . On at 09:45 AM, the administrator stated, "Most of the we have are just slid down. (sic) We ask them if they , they said no they slid down from the bed. We mark them as , but they are not really falling. We ask them if they want to go to the hospital. If they refuse, we give them a statement to sign." On at 09:49 AM, a case manager from the guardianship program stated the residents should not make any medical care decision. She stated, "They are unable to make medical decisions. We have all rights regarding medical decisions, not the resident. They should call us if a resident refuses treatment. The residents under guardianship program cannot consent or sign any medical documents." C) A review of Resident #25's record showed the resident was admitted to the facility on . The health assessment done on indicated the resident was diagnosed with , History , Sleep , , Carotid , stenting, , History of , prostatic hyperplasia ( ), , Atherosclerotic , , and . The resident needed supervision with bathing and was independent with the rest of the activities of daily living. A review of Resident #25's progress notes dated showed that "resident was observed on the floor. The resident stated he was	A 027		

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A 027	Continued From page 21 transferring to the wheelchair and . He stated that he is okay not having any , , don't need to go to the hospital. He refused to go to the hospital." A review of Resident #25's progress notes dated showed, "resident has small on right , no noted. Resident educated on safety precautions with wheelchair." On at 8:30 AM, Resident #25 stated "I in the bathroom and hit my and have a on my that the nurse is taking care of it." On at 9:27 AM, Resident #25's sister stated the resident called her to let her know that he on at 1:23 AM between the sink and toilet and cut himself on the and . She further stated that the facility did not contact her until the next day of the resident's . There was no documentation that his health care provider was notified regarding Resident's #25 on and . Class III	A 027		
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	A 030		

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A 030	Continued From page 22 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 and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery	A 030		

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A 030	Continued From page 23 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) 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,	A 030		

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A 030	Continued From page 24	A 030		

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 religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate

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A 030	Continued From page 25	A 030		

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 person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right

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A 030	Continued From page 26 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.- (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	A 030		

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	AL11953671	A. BUILDING: _____ B. WING _____	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT LAKES	280 SIERRA DRIVE NORTH MIAMI BEACH, FL 33179

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A 030	Continued From page 27 . . . , . . . 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: Based on observation and interview, the facility failed to treat with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. The facility failed to provide all facility residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication. The facility has a licensed capacity of 17 or more residents and does not have a readily accessible telephone on each floor of each building when residents reside. Findings included: Observation on at 09:15 AM showed the facility had a census of 132 residents in a 4-story building. Observed the facility had no telephone service on any of the floors. Observation also revealed the residents had no telephone services or any other device in their apartment to call for assistance. On at 01:25 PM, Resident #6 expressed his concern of not having a way to call for assistance. Resident #6 stated, "I need	A 030		

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A 030	Continued From page 28 assistance to move to my bed and from my bed to this wheelchair. I wanted to talk to you. I have . . . . . , right. They need to have a phone or call button in the room. Like me, I cannot walk or go anywhere. If I , I have to wait until someone come to my room; that's not right. It should not be like that. I spoke to the administrator before, but I have not seen any change. I have not for the past year, but I feel like they should put an emergency call light in the bathroom. I don't take my cell phone to the bathroom, you know. I'm not complaining about staffing, but I think they should have the call light." On . . . . . at 02:00 PM, Staff F stated, "during the time I'm here, the CNA (Certified Nursing Assistants) and HHA (Home Health Aide) do two hours rounds. Some residents have cell phone. If they need assistance they will call me, and I will radio the staff. The residents don't have a phone in their rooms. Not all the residents have cell phones. If a person and does not have a cell phone, I guess they will have to wait until the staff go to their room. They used to have a buzzer by the . . . of their beds and in the bathrooms. They removed them sometimes ago. When they pressed the buzzer, it would show in my screen as 911 and the room number. They will get the help right away, but now I don't know. I don't know why they removed them, but they did. I wished they did not remove them because like you said, if a resident needs help and not having a phone, I don't know what going to happen." On . . . . . at 10:30 AM, Resident #17 stated, "I don't have a cell phone. I don't have any way to contact the staff if I need something. The staff come here very often, like every 45 minutes or 1 hour. If I need help I guess I have to go downstairs or wait until they come up here. I walk	A 030		

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A 030	Continued From page 29 using this walker." On [redacted] at 01:50 PM, asking Resident #7 about calling for assistant, Resident #7 stated, "No, I don't have any phone in my room. I don't have a cell phone neither. I don't have any way of calling for assistance when I'm in my room. I'm glad I have not [redacted], but if I do I don't know what would happen. I need help to get on and out of this wheelchair." Class III	A 030		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. [redacted]; 2. or , damage; 3. Permanent [redacted];	A 165		

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A 165	Continued From page 30 4. . . . . or . . . . . of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall	A 165		

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A 165	Continued From page 31	A 165		

determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The agency may adopt rules necessary to administer this section.

59A-36.016 Adverse Incident Report.
(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting.
(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within

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A 165	Continued From page 32 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed summit an adverse incident report on two incidents for one out 24 sample residents (Resident #17). Finding include: A) A review of Resident #17 Demographic Report on , the report showed that the resident was admitted on . A review of Resident #17 Observation Log dated at 1:45 PM, it showed "assigned Certified Nursing Assistant/Home Health Aide alerted Medication Technician. Resident is and has alter mental status, resident started to decline, and was very slow to responds. Resident has Narcan due to similar symptoms in the past". Nursing staff administer the medication to the resident. After two doses of the medication the resident became more alert and oriented. The resident was transported to the local hospital via ambulance service. A review of the Resident #17 Hospital Record dated , the record showed "resident with a past medical history of heroin , acute , and . Resident supposedly overdosed on pills which she has been hiding in her purse". Resident was diagnosed with opiate overdose. In an interview on at 12:47 PM, the	A 165		

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A 165	Continued From page 33 Administrator stated that no adverse incident report was send to the state because of the resident overdose. The administrator stated a "report is done if it can be prevented. This could not be prevented". B) A review of Resident #17 Observation Log dated . . . . . , the report showed that the resident was sent to the local hospital due to a . Primary Care Provider and Guardian were notified. A review of Resident #17 Hospital Record dated . . . . . , the record showed that the resident was admitted to the hospital due to right , . The , started yesterday (. . . . .) due to a mechanical in the Assisted Living Facility. The resident was diagnosed with a 2-part displaced of surgical of right . . . . . , initial encounter for closed . . . . . In an interview with Staff B on . . . . . at 3:20 PM, regarding the adverse incident report, the Administrator stated that the incident was not reported. "I don't know why". Class III	A 165		
AL240 SS=D	429.075; 59A-36.020(1) LMH - Licensing 429.075 Limited mental health license.-An assisted living facility that serves one or more mental health residents must obtain a limited mental health license. 59A-36.020 Limited Mental Health. (1) LICENSE APPLICATION. (a) Any facility intending to admit one or more	AL240		

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AL240	Continued From page 34 mental health residents must obtain a limited mental health license from the agency before accepting the mental health resident. (b) Facilities applying for a limited mental health license that have uncorrected deficiencies or violations found during the facility's last survey, complaint investigation, or monitoring visit will be surveyed before the issuance of a limited mental health license to determine if such deficiencies or violations have been corrected. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a Limited Mental Health license before admitting mental health residents for one out of (Resident #17) sampled residents. Findings Include: Record review of Resident #17 health assessment dated indicated the resident was diagnosed with Major (MDD), unspecified and Facility record review showed Resident #17 received $54.00 for payment. Interview conducted on at 2:45 PM, Administrator stated they did not know how many residents received payment because the residents received the payment directly to them. She stated that the checks are delivered with residents names and the staff placed them in resident's mailboxes, then the residents would go to the store to cash them.	AL240		

Agency for Health Care Administration

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AL240	Continued From page 35 Class III	AL240		