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 _____	R 08/02/2021

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 A revisit to a Change of Ownership and a Complaint Investigation (Complaints #2021001948 and 2021005856) was conducted at Grand Court Lakes on to . Deficiencies were identified at the time of the survey.	{A 000}		
{A 025} SS=I	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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{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 record review and interview, the facility failed to provide adequate supervision for each resident to ensure awareness of the general health, safety, physical and emotional well-being for five out of 33 sampled residents (Resident # 19, #25, #28, #32, #33). Resident #28 was found by fire rescue lost after having eloped from the facility. Residents # 19, # 25, and # 33 were all transferred to the hospital after falling at the facility. 1) A review of the facility's admission/discharge log showed Resident #28 was admitted on	{A 025}		

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{A 025}	Continued From page 2 . . . . . and was discharged on . . . . . A review of the facility's hospital log showed that Resident #28 was transferred to the hospital on . . . . . and returned to the facility on . . . . A review of Resident #28's progress notes showed no documentation of why the resident was sent to the hospital. In an interview on at 11:07 AM, Staff F stated that she did not remember what had happened to Resident #28 but that she was not feeling good that day. On at 11:08 AM, the Director of Nursing stated, "I believe it was an elopement. I came and they were discussing it had been an elopement. Earlier that day, she was not feeling good, and they were going to send her to the hospital. The police found her." On at 9:54 AM, Resident #28's mother stated, "I called around 5 or 6 in the afternoon to talk to her, and they could not find her. That place had no supervision, was not secured. Then when I was on the phone with them, my daughter called me from the [hospital]. She said that she had gone for a walk and got lost, that people found her and brought her to the hospital. Later I found out that it had been the rescue. The rescue was passing by and saw her ., , and she could not tell them where she lived, so they took her to the hospital." A review of Resident #28's hospital record showed a 'History of Present Illness' of a female with a history of , , ALF resident due to neurologic status, presents brought in	{A 025}		

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{A 025}	Continued From page 3 by Emergency Medical Services ( ) for bizarre behavior after elopement from the ALF (Assisted Living Facility). The patient states that she went for a walk this morning away from the ALF and got lost. reports that they were called to find her acting strangely at a gas station some distance away from her facility. She states that she had a history of multiple recent , , admissions last one month ago." A review of the facility's elopement policy and procedures showed, "Should a resident not sign out in the facility's sign/in-out log recording their name, date, and reason for the temporary absence nor communicate with staff regarding his/her temporary absence, the facility there understands that the resident left the facility without following the policy and procedures. When a resident is determined missing or their whereabouts unknown, the facility shall make every attempt as quickly as possible to locate the resident." A review of the facility's sign-in/out log dated showed Resident #28 did not sign out when she left the facility. A review of Resident #28's progress notes showed no documentation of the resident eloping from the facility. In an interview on at 12:23 PM, Staff G stated, "I was working the day that [Resident #28] got lost. She had been here about two weeks, and she would sit close to me. I did not see her, so I asked someone to look for her in her room, she was not found. She never left through the front door because I checked the cameras. There was a hole in the gate, and she went through it to the independent side. I do not know	{A 025}		

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{A 025}	Continued From page 4	{A 025}		

who called the police; she ended up at [hospital], she called her mother, and her mother called me. I had seen her probably an hour before she was gone."

During an interview on at 12:37 PM, when asked about Resident #28's elopement, the administrator stated, "It happened on the weekend, and they called me. That day she was pacing and forth and looked like she went out. Somebody saw her in the area and called 911. Her mother called to tell me to call [hospital] because her daughter was there."

A review of Resident #28's undated health assessment showed medical diagnoses and a history of , , and , . The resident was independent with eating, toileting, transferring, and needed supervision with ambulation, bathing, and grooming. The health assessment indicated that the resident was not an elopement risk.

A review of Resident #28's records showed no documentation of the resident being reassessed by facility staff after the elopement.

On at 12:38 PM, when asked precautions were put in place after Resident #28 eloped from the facility; the administrator stated, "I don't remember on the top of my what we did after she eloped."

During an interview on at 10:15 AM, when asked if the facility gave her daughter any identification with their address listed, Resident #28's mother stated, "That place was supposed to give her a with her name and address, and they did not."

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{A 025}	Continued From page 5 A review of the agency's adverse incident database showed no incident reports were filed for Resident #28 elopement. During an interview on at 12:37 PM, when asked whether Resident #28's elopement was reported to the agency, the administrator stated, "No, I did not file an incident report." 2) A review of the facility's incident report dated showed that staff was notified to go to Resident #19's room. Upon arrival, the resident was found lying on the floor in the supine position. When asked what happened, Resident #19 stated, "while turning and changing position, I rolled out of bed to the floor." The resident denied hitting her but complained of . When asked whether she would like to go to the hospital, the resident refused. A review of Resident #19's progress notes dated showed "per MedTech resident was observed on the floor. The resident stated while turning position on her bed and . Non-emergency was called, and resident sent out to the hospital." A review of the hospital records dated showed a 'History of Present Illness' of "female-presenting to the emergency department for , status post- . Slipped and at home per the patient. The patient has a of the T- , . But reporting worsening , today. Concern for worsening , or new-onset ." In an interview on at 2:05 PM, when asked whether Resident #19 before , the Director of Nursing, "She has before this month. She had a on , and on ."	{A 025}		

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{A 025}	Continued From page 6 A review of the facility's incident log revealed that Resident #19 three times from months through . A review of Resident #19's health assessment dated showed medical diagnoses and a history of , history of skin , history of , and . The resident was independent with self-care, eating, and needed supervision with ambulation, bathing, , and toileting. The health assessment indicated that the resident had no precautions. A review of Resident #19's records showed no documentation of an updated health assessment after Resident #19's . On at 2:16 PM, the Director of Nursing stated that Resident #19's physician indicated no precautions on the resident's health assessment in error. She further said, "She already had two , and we discussed it." A review of the facility's management policy and procedures showed the facility "completes a risk of falling assessment when the resident's health assessment or any pre-admission document specifies precautions when the resident has twice in one month resulting in injury or , if the resident's present condition indicates that they are at risk for or if the resident's health care provider's notes reflect that the resident is at risk for . A review of Resident #19's record showed no documentation of a completed risk of falling assessment. There was also no documentation of	{A 025}		

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{A 025}	Continued From page 7 the precautions which had been in place at the time of the resident . A review of the primary care provider notes dated showed, "patient seen for follow up custodial visit at the ALF. The patient appears to be in no apparent distress, complaining of increasing and . The patient is followed by . The patient states she does not want an , as suggested by . The patient is unable to complete her ADLs independently and requires assistance with ambulation. Patient reports feeling weak." During an interview on at 12:15 PM, Resident #19's primary care provider stated, "I tried to get her , but she refused. She is , and she was always focusing on that. She probably needs to go to a nursing home." 3) A review of the facility's incident report dated showed "housekeeping called MedTech/nurse to come to [Resident #25's] room due to resident had , upon arrival, MedTech/nurse observed resident lying on his on the floor, and noted on resident's right arm. It was asked to resident how he , and he stated, "I went to the bathroom to urinate while trying to hold the rail. I to my right side and crawled to the room." A review of Resident #25's progress notes dated showed that the resident was found on the floor by housekeeping. The Assistant Director of Nursing and a MedTech arrived at the resident's room and assisted him up. The resident was noted to have a on his right . A review of a second facility incident report dated	{A 025}		

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{A 025}	Continued From page 8 . . . . . showed "[Resident #25] observed upon rounds lying on the floor on his between the nightstand and headboard with . . . . coming from the left side of his . Upon evaluation, a . . . . . was noted on the left side. The resident stated, "I was transferring from the bed to wheelchair; my . . got weak, and I lost my balance. I , hitting my on the nightstand." As per the lead staff member, 911 was called, and resident refused even with encouragement from paramedics, administrator, and sister." A review of Resident #25's progress notes dated . . . . . showed, "resident was observed beside his bed in a pool of per MedTech lying on his . . . . Resident stated he was transferring from bed to wheelchair his . got weak and his lost his balance and hit his . . . by the nightstand. 911 was called. Resident refused to go to the hospital." Review of Resident #25's progress notes dated showed that on , the administrator was contacted by the night shift MedTech stating the resident was found on the floor next to his nightstand. The night shift nurse contacted 911, and when fire rescue arrived, they advised that the resident be transferred to the hospital due to the on his . Resident #25 refused to go with fire rescue for treatment. The resident's sister was contacted to encourage the resident, but he still refused. On at 11:28 AM, staff tried once again to convince Resident #25 to go to the hospital, and once again, he refused, stating, "I want to die and be in heaven with my parents." Staff notified the Director of Nursing, and non-emergency police were called for a possible . When the police arrived, the resident agreed to be	{A 025}		

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{A 025}	Continued From page 9 transferred to the hospital. A review of Resident #25's hospital record showed a 'History of Present Illness' of a male with a history of [redacted] Pia, [redacted] prostatic hyperplasia, [redacted] dependent on a wheelchair who brought in by [redacted] secondary to having a [redacted]. The patient stated two days ago, he had a [redacted] and injured his left parietal [redacted]. Per [redacted] patient had a [redacted] while transferring from bed to a commode. The patient stated he only sustained an injury to his [redacted]. The patient states his [redacted] worsens with palpation." A review of Resident #25's health assessment dated on [redacted] showed medical diagnoses and a history of [redacted], history [redacted], sleep [redacted], history of [redacted] prostatic hyperplasia, [redacted]. The resident was independent with ambulation, [redacted] eating, self-care, toileting, transferring, and supervision with bathing. The health assessment indicated that the resident had precautions. A review of Resident #25's records showed no documentation of the resident being reassessed after his multiple [redacted]. On [redacted] at 9:58 AM, the Director of Nursing stated, "I spoke to the primary care provider about him getting reassessed because he has some [redacted]."	{A 025}		

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{A 025}	Continued From page 10 During an interview on at 11:35 AM, Staff F stated that Resident #25's always occurred when transferring to his bed from his wheelchair. In an interview on at 11:37 AM, when asked what type of assistance staff was providing to Resident #25 to prevent his , Staff F stated: "Nothing, he is independent." On at 11:27 AM, when asked what preventive measures to prevent Resident #25's , the Staff I stated, "We installed a second garb bar in the bathroom and ordered physical/ , , ." When asked about how long Resident #25 was receiving , , the Staff I stated, "not yet; we requested it on , and he went to the hospital on ." In an interview on at 12:20 PM, Resident #25's primary care provider, "[Resident #25] has had a couple of recently. Mentally he was okay, but physically he was declining. We prescribed physical/ , , , but it didn't start." A review of the facility's management policy and procedures showed the facility "completes a risk of falling assessment when the resident's health assessment or any pre-admission document specifies precautions when the resident has twice in one month resulting in injury or , , if the resident's present condition indicates that they are at risk for or if the resident's health care provider's notes reflect that the resident is at risk for . A review of Resident #25's record showed no	{A 025}		

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{A 025}	Continued From page 11 documentation of a completed risk of falling assessment. 4) A review of the facility incident report dated showed that staff was notified that Resident #32 was on the floor. The resident was observed on the floor in a sitting position. When asked how he , the resident stated that he was attempting to transfer from his bed to the wheelchair and lost his balance. A review of Resident #32's progress notes dated showed, "CNA called MedTech stated resident is on the floor. Upon arrival, observed resident in a sitting position in his room by his bed. When asked, the resident stated he lost his balance while transferring from bed to wheelchair and forgot to lock his wheelchair. Resident denies , , vitals well, resident was able to move all extremities." A review of a second facility incident report dated at 6 PM showed "MedTech alerted via dining room staff, that [Resident #32] was on the floor, upon arrival resident was observed lying on the floor complaining of , . When asked how he , he stated, "I was stretching in my wheelchair, and I slipped down to the floor." The Director of Nursing was called for evaluation due to his left arm and being extended. 911 was called, resident evaluated Fire Rescue assessment completed and it was said that the resident was fine." A review of Resident #32's progress notes dated showed that staff in the dining room alerted the MedTech that the resident was lying on the floor. The Director of Nursing completed an assessment due to the resident's complaint of left arm , . 911 was called, and Fire Rescue	{A 025}		

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{A 025}	Continued From page 12 came to evaluate the resident in which; they stated that the resident was "fine." On [redacted] were completed on the resident, and no [redacted] were found. A review of Resident #32's health assessment dated [redacted] showed medical diagnoses and a history of Type 2 [redacted] with [redacted], history of [redacted] purpura, [redacted], mild proliferative [redacted] D deficiency, [redacted], history of multiple [redacted], history of [redacted], and [redacted]. The resident needed supervision with [redacted] and assistance with ambulation, bathing, toileting, and transferring. The health assessment indicated that the resident needed [redacted] precautions. A review of the facility's incident log revealed that Resident #32 [redacted] five times between [redacted]. In an interview on [redacted] at 2:25 PM, when asked whether Resident #32 has [redacted] before [redacted], the Director of Nursing stated, "Yes, he slipped on [redacted]." A review of the facility's [redacted] management policy and procedures showed the facility "completes a risk of falling assessment when the resident's health assessment or any pre-admission document specifies [redacted] precautions, when the resident has [redacted] twice in one month resulting in injury or [redacted], if the resident's present condition indicates that they are at risk for [redacted] or if the resident's health care provider's notes reflect that the resident is at risk for [redacted]. A review of Resident #32's record showed no	{A 025}		

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{A 025}	Continued From page 13 documentation of a completed risk of falling assessment. There was also no documentation of the precautions in place at the time of the two resident . On at 2:28 PM, when asked what precautions were put in place to prevent Resident #32 from continuing to , the Director of Nursing, stated "He isn't falling but slipping from his wheelchair. We notified the primary care physician, and he tried to get him a wheelchair on , but it never came. So, we ordered an cushion, which came in on ." 5) A review of the facility's incident report dated showed, "[Resident #33] was found lying on the floor in the bathroom. The resident stated, "I tried to use the bathroom without the walker and " Lead staff asked the resident if he was in /discomfort. The resident replied, "Yes." 911 called, when arrived paramedic took resident vital signs, they did an assessment resident in and then taken to [hospital]." A review of Resident #33's progress notes showed no documentation of the resident's . A review of Resident #33's hospital record showed a 'History of Present Illness' of male presents complaining of acute onset of right , . Pain is described as severe located at the right lateral , aggravated with movement, -bearing, palpation, alleviated with remaining still." A review of Resident #33's health assessment dated showed medical diagnoses and a history of , , , advanced , , gait ataxia, , dry , , and	{A 025}		

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{A 025}	Continued From page 14 . . . . . The resident was independent with ambulation, eating, self-care and needed supervision with ambulation, , toileting, and transferring. The health assessment indicated that the resident had precautions. A review of the primary care provider notes dated . . . . . showed, "Patient seen for a follow up monthly custodial visit at the ALF. The patient is unable to complete his ADLs independently and requires assistance with ambulation." In an interview on at 12:18 PM, Resident #33's primary care provider stated, [Resident #33] can transfer by himself; however, he needs assistance to get dressed, bathing, and she won't do things if he isn't prompted. He was already getting , , ... , , . He has declined in the last six months." A review of the facility's management policy and procedures showed the facility "completes a risk of falling assessment when the resident's health assessment or any pre-admission document specifies precautions, when the resident has twice in one month resulting in injury or , , if the resident's present condition indicates that they are at risk for or if the resident's health care provider's notes reflect that the resident is at risk for . . A review of Resident #33's record showed no documentation of a completed risk of falling assessment. There was also no documentation of the precautions that were put in place. During an interview on at 1:22 PM, the Director of Nursing stated that they have not implemented yet the risk assessments as it	{A 025}		

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{A 025}	Continued From page 15 will take a while to go through all the residents' records. Class II	{A 025}		
{A 030} SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.	{A 030}		

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{A 030}	Continued From page 16 (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical	{A 030}		

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{A 030}	Continued From page 17	{A 030}		

by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . .

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from . . . . . and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the

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{A 030}	Continued From page 18 resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . , , ... for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and	{A 030}		

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{A 030}	Continued From page 19	{A 030}		

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 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

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{A 030}	Continued From page 20 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 , 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 all residents 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	{A 030}		

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{A 030}	Continued From page 21 capacity of 191 residents and does not have a readily accessible telephone on each floor when residents live. Findings included: Observation on [redacted] at 8:32 AM showed the facility had a census of 124 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 apartments to call for assistance. In an interview on [redacted] at 1:40 PM, Staff I stated that the facility was in the process of getting quotes for the installation of the phones. She also noted that the phones would be installed by the end of [redacted]. Class III	{A 030}		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an [redacted] syringe that is prefilled with the proper dosage by a pharmacist and an [redacted], that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication	A 052		

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A 052	Continued From page 22	A 052		

from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident ' s medications or dosages change.
(c) Placing an oral dosage in the resident ' s or placing the dosage in another container and helping the resident by lifting the container to his or her .
(d) Applying , medications.
(e) Returning the medication container to proper storage.
(f) Keeping a record of when a resident receives assistance with self-administration under this section.
(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .
(h) Using a to perform - level checks.
(i) Assisting with putting on and taking off stockings.
(j) Assisting with applying and removing an but not with titrating the prescribed settings.
(k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.
(l) Assisting with measuring vital signs.
(m) Assisting with bags.
(4) Assistance with self-administration does not include:
(a) Mixing, , converting, or medication doses, except for

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A 052	Continued From page 23 measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and	A 052		

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must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule.
(b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with

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A 052	Continued From page 25 this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, one out of nine sampled staff (Staff H) failed to confirm in the presence of one out of thirty-three sampled residents (Resident #31) that the medication was intended for him and orally advising the resident of the medication name and dosage. The staff also failed to place the medication directly into the resident's or a container. Findings included: On at 8:05 AM observation showed during medication pass that Staff H (Medication	A 052		

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A 052	Continued From page 26 Technician) assisted Resident #31 with the self-administration of medication. Further observation showed that Staff H was not wearing gloves and touched the medications (Capsules, 180 mg, Align Probiotic, , , , ,) with her bare . Staff H did not read aloud the medication prior to give it to Resident #31. When asked if the resident had signed a waiver so that the names of his medications would not be provided, Staff H replied, "I don't know." Personnel record review showed that Staff H completed 4 hours on initial training for assistance with the self-administration of medication on and a 2 hour update on . On at 12:02 PM, the Administrator acknowledged the findings. Class III	A 052		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom	A 152		

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	AL11953671	A. BUILDING: _____ B. WING _____	R 08/02/2021

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A 152	Continued From page 27 or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment to residents and to ensure that all existing architectural, mechanical, electrical, and structural systems, and appurtenances are maintained in good working order. Findings included: 1) On at 8:10 AM, observation showed two live cockroaches running around the shower in # . On at 8:22 AM, during an interview	A 152		

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A 152	Continued From page 28 Resident #5 stated, "I had seen cockroaches in my room and the maintenance guys picked them up this morning. I had killed 3 of them." 2) On [redacted] at approximately 8:15 AM, observation showed floor in dining room of Memory Care Unit contained food residue, debris, and small pieces of trash. On [redacted] at 12:02 PM, the Administrator acknowledged the findings. Class III	A 152		
{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 29 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 30	{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 31 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 to file an adverse incident report with the Agency for Health Care Administration within one business day and fifteen days for one out of 33 sampled residents (Resident #28). Findings include: A review of the facility's admission/discharge log showed Resident #28 was admitted on [redacted] and was discharged on [redacted]. During an interview on [redacted] at 12:37 PM, the Administrator stated, "It happened on the weekend, and they called me. That day she was pacing and forth and looked like she went out. Somebody saw her in the area and called 911. Her mother called to tell me to call [hospital] because her daughter was there." On [redacted] at 9:54 AM, Resident #28's mother stated, "I called around 5 or 6 in the afternoon on [redacted] to talk to her, and they could not find her. That place had no supervision, was no secured. Then when I was on the phone with them, my daughter called me from the [hospital]. She said that she had gone for a walk and got lost, that people found her and brought her to the hospital. Later I found out that it had been the rescue. The rescue was passing by and saw her [redacted], and she could not tell them where she lived, so they took her to the hospital."	{A 165}		

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{A 165}	Continued From page 32 A review of the agency's adverse incident database showed no incident reports were filed for Resident #28 elopement. During an interview on at 12:37 PM, when asked whether Resident #28's elopement was reported, the administrator stated, "No, I did not file an incident report." Class III	{A 165}		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident	A 200		

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must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.
a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an

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alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary.
b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan.
c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage.
(b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage.
1. Facilities must store minimum amounts of fuel onsite as follows:
a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite.
b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite.

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A 200	Continued From page 35 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . . monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency Rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that	A 200		

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A 200	Continued From page 36 undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule.	A 200		

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A 200	Continued From page 37 (b) The Agency shall allow an extension up to , , to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either: a. Fully and safely evacuate its residents prior to the arrival of the event; or	A 200		

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A 200	Continued From page 38 b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to	A 200		

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A 200	Continued From page 39 produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate	A 200		

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 _____	R 08/02/2021

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 200	Continued From page 40 must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure air temperatures were maintained at or below 81 degrees Fahrenheit in resident's rooms. Findings included: On at 8:10 AM observation showed in # the thermostat in the wall showed temperature in the room was at 83	A 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 200	Continued From page 41 degrees Fahrenheit. On [redacted] at 12:02 PM, the Administrator acknowledged the findings. Class III	A 200		