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
	AL11942866	A. BUILDING: _____ B. WING _____	R 09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments An unannounced second revisit survey was conducted on [redacted] through [redacted] at The Courtyards Assisted Living, an assisted living facility In Punta Gorda, Florida. This was a follow-up to the revisit survey completed on [redacted], which was in response to the relicensure, emergency power plan monitoring, focused [redacted] control, and complaint survey that was completed on [redacted]. This survey was conducted in conjunction with new complaint surveys. The following is description of the deficiencies found at the time of the visit. .	{A 000}		
{A 025}	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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	{A 025}		

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{A 025}	Continued From page 1 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) 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 observations, record review, and staff and resident interviews, the facility failed to provide care and services appropriate to the	{A 025}		

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{A 025}	Continued From page 2 needs of residents and maintain a general awareness of the residents' whereabouts for 2 {Resident #20 and #23} of 2 residents reviewed for elopement. This is an uncorrected deficiency. The findings included: Review of facility policy for Identification and Supervision of [redacted] Residents at Admission. Purpose- 1. To identify and manage residents at risk for [redacted]. 3. To provide a method for community and company wide analysis of residents/elopement incident. Procedure: The Elopement Assessment Tool will be completed: A. On admission, semiannually and after any [redacted]/elopement incident. 3. If the community has a resident elopement incident, the Executive Director/designee will initiate a [redacted]/Elopement Monitoring Report. To complete the [redacted]/Elopement Monitoring Report the following information must be included. A. Elopement Assessment Tool. B. Incident/accident report. C. Missing Resident checklist (Phase 1 and 2). D. documentation in the residents chart. 1. Review of the facility's adverse incident reports since the last survey the following was discovered. A. Incident date [redacted] - an event reported to law enforcement for investigation. Resident #20 had eloped from the facility. The facility's administrator filed an Adverse Incident Report because of police involvement and wrote in circumstances of the incident, Resident #20 had	{A 025}		

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{A 025}	Continued From page 3	{A 025}		

a diagnosis of , and the facility received a call from the police that Resident #20 was picked up at the corner store and they were bringing her to the facility. The sheriff was called by the store employees. The sheriff brought the resident to the facility. No education was done for current staff for elopement.

Record review of Resident #20's Health Assessment Form 1823 dated indicated the resident had a diagnosis of , , and for which she was on medication.

Review of Resident #20's Observation Log revealed the following: - "about 6:00 a.m., Resident #20 went out the door and walked down to the store and down and broke her right arm, and the cops picked her up and brought her and was sent to the ER to get treatment and came and was seen by the psych ARNP V and was and sent to Riverside because she would not take her medications." This note was written by Medication Technician (MT) Staff L.

Review of Resident #20's Medication Observation Record (MOR) revealed she had been refusing all of her of her medication for the month of up to the time she eloped from the facility and when she returned to the facility before she was to Riverside Behavioral Center.

Interview on at 8:38 a.m., MT Staff L said Resident #20 had been refusing her medications for a long time now and has lots of psych issues. She stated Resident #20 eloped from the facility recently again on . Staff did not know she

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{A 025}	Continued From page 4 was not in the facility until the sheriff's police called and notified the facility staff, they had Resident #20 and was going to return her to the facility. Observation on at 10:15 a.m., revealed Resident #20 was around the facility, and no staff were monitoring. Interview on at 10:47 a.m., ARNP W said Resident #20 has so many psych issues and in her professional opinion should not be outside the facility unsupervised. Interview on at 9:17 a.m., Resident Aide ( ) Staff H said on the day Resident #20 eloped staff heard the alarm go off and when they looked they did not see anyone. She said the staff never did a count of the residents in the facility to make sure no one was missing and the resident had already gotten out the door and gone down the road. The employees at the corner store saw the resident and called the sheriffs office. Staff H confirmed staff did not know Resident #20 was not in the facility until the sheriff's office called to notify them they had the resident and was returning her to the facility. Staff H said the facility does not use the Elopement assessment tool/form after there is any elopements by the residents, and there is no education done with staff for elopement after the incidents. Interview on at 9:01 a.m., MT Staff L stated staff are to monitor Resident #20 daily as she has eloped from the facility a couple of times. The staff don't pay attention and don't come to work, and its hard to keep on the resident when they are doing other things. She said the Administrator does not seem to care and hires	{A 025}		

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{A 025}	Continued From page 5 people who don't come to work. Interview on [redacted] at 12:15 p.m., ARNP Staff W said she was "generally" aware Resident #20 had been refusing her medication over the last couple of months. The ARNP said the resident would be safe here if the facility followed safety protocol and monitored people, alarms and doors being secured. She said the resident is not safe to leave the facility unsupervised because of her diagnosis of [redacted] and [redacted]. Interview on [redacted] at 10:30 a.m., Psych ARNP Staff V said she was aware Resident #20 had been refusing her medications after her prior elopement and continued to refuse her medications which is why she deemed it necessary to [redacted] Resident #20 after this current elopement for treatment. The ARNP said Resident #20 is not safe to be outdoors or leave the facility unsupervised. Interview on [redacted] at 12:19 p.m., Administrator said he was unaware ARNP W and ARNP V felt medically Resident #20 should not be outside of the facility unsupervised. 2. Review of the facility's adverse incident reports since the last survey the following was discovered. B. Incident date [redacted] - an event reported to law enforcement for investigation. The facility's Administrator filed an Adverse Incident Report because of police involvement and Resident #23 had eloped from the facility and wrote in the circumstances of the incident, Resident #23 who was diagnosed with [redacted] and declared [redacted] by the courts, had eloped from the facility and was seen at the	{A 025}		

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{A 025}	Continued From page 6 corner store parking lot by staff on his way to work about 8:00 a.m. The sheriff department was called when staff went to the corner store to bring the resident to the facility and Resident #23 could not be located. A search was organized. The police brought Resident #23 to the facility around 12:00 p.m. Staff were unaware of Resident #23's whereabouts until seen by a staff when driving to work. No staff education was done for current staff for elopement. Corrective action summary indicated all exit doors will be alarmed and kept always locked, and a guard will be attached to Resident #23's wheelchair which will trigger a separate alarm at the nursing station if he leaves the facility. Review of Resident #23's Medication Observation Record (MOR) revealed he has been refusing all of his medications for the month of . Interview on at 11:10 a.m., revealed Resident #23 had a communication and was unable to speak. He was only able to voice the word "yes" when asked any questions. Resident was observed dressed appropriately and sitting in wheelchair. No was observed on Resident #23's wheelchair or person. Interview on at 2:04 p.m., housekeeper/ Staff I said Resident #23 has had elopements within the last 2 months. She said there had been incidents where he eloped and was found at the corner store drunk after purchasing and the police brought him to the facility. She said the facility exit doors are always unlocked and the alarm is always off. Staff I said there is a box in the office for a and it does not work.	{A 025}		

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{A 025}	Continued From page 7 Interview on at 9:43 a.m., MT Staff L said Resident #23 had been refusing to take his medications for months , as he does not want to be at the facility. He has eloped multiple times from the facility with the last time Resident #23 eloped being in . Staff L said she received a screen shot of an article that was being broadcast on the television about a missing resident who was Resident #23. Staff L said the facility exit doors are always unlocked and never alarmed, and she has never seen a on Resident #23's wheelchair. She confirmed there is a box in the nurse's station, but she has never heard it alarm. Observation on at 10:15 a.m., revealed Resident #23 propelling himself through the facility, with no staff monitoring and no on his wheelchair. Observation on at 10:25 a.m., with Med Tech Staff L revealed Resident #23's wheelchair had no . Staff L confirmed there was no on Resident #23's wheelchair. Interview on at 10:47 a.m., ARNP W said Resident #23 "will continue to elope from the facility and there is nothing that she can prescribe or say that will stop him, as he is determined he does not want to be at the facility." Interview on at 11:34 a.m., ARNP W confirmed Resident #23 is an elopement risk, and she had not completed an updated Health Assessment Form 1823 indicating that status as she did not think it was required. Observations on at 2:20 p.m. through 2:34 p.m., revealed front lobby and entrance of the	{A 025}		

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{A 025}	Continued From page 8 facility with no front office staff or resident aides watching the entrance to observe any staff or residents entering or exiting the facility, and no alarm or lock engaged on the front entrance to notify staff or anyone entering or exiting the facility including residents and or visitors. Observation on at 10:25 a.m., during a tour of facility with Staff L, revealed exit doors #2, #7 by 100 hallway; #6 by courtyard; #4 and #5 by kitchen hallways leading to exterior of the facility; exit door #3 by women's bathroom leading to exterior of the facility to the parking lot, were all opened by Staff L. No alarms engaged and none of the exit doors locked. Staff L confirmed all exit doors were unlocked and no alarms were engaged on the exit doors which creates the hazard of residents eloping from the facility. Interview on at 12:43 p.m., the Administrator confirmed Resident #23 has had multiple elopements from the facility. He confirmed Resident #23 eloped from the facility as the doors were not locked and alarmed. The police were called and the resident was found on Kings Highway and returned to the facility by the police. The Administrator said the corrective action to prevent further elopements by Resident #23 was to install a on Resident #23's wheelchair and keep all facility exit doors locked and always alarmed. Administrator confirmed he has never completed the Elopement assessment tool on any of the facility residents when there was an incident of elopement, and none was completed on Residents #20 and #23. Observation on at 1:00 p.m., during a tour of facility with the Administrator revealed Resident #23's wheelchair had no	{A 025}		

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{A 025}	Continued From page 9 Administrator confirmed no guard on Resident #23's wheelchair. Tour of all facility exit doors with Administrator revealed all exit doors were unlocked with no alarms engaged on the doors, the Administrator confirmed all the facility exit doors were unlocked and no alarms were engaged on the doors. He said, "he can't control what his staff does, they are to keep the doors alarmed." Administrator said after the elopements all he does is the adverse incident reports. He said whatever is in the adverse report is what he uses for his investigation it does not make sense to do anything else. The adverse is his investigation, he does not do an incident report. Observation on at 9:59 a.m., revealed Residents #23 and #20 were sitting in the front lobby of the facility, with no staff in the front office and no staff monitoring. The alarm on front door disengaged. Office staff was working in the kitchen as the kitchen staff called off sick. Class II	{A 025}		
{A 030}	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	{A 030}		

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{A 030}	Continued From page 10	{A 030}		

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 of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation.

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{A 030}	Continued From page 11 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, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate	{A 030}		

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{A 030}	Continued From page 12	{A 030}		

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 and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of

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{A 030}	Continued From page 13 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 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	{A 030}		

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{A 030}	Continued From page 14 special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, [illegible], 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 [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], 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 [illegible] Hotline operated by the Department of Children and Families, and [illegible], 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 [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and	{A 030}		

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{A 030}	Continued From page 15 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, record review, and staff and resident interview, facility failed to safeguard residents' well-being by not following current control standards related to COVID-19 recommendations set forth by Centers for Control and Prevention (CDC). Further, the facility failed to ensure Residents' Rights to live in a safe, decent living environment free from and neglect for 3 (Residents #20, #23 and #28) of 3 residents reviewed for adverse incidents. This is an uncorrected deficiency. The findings included: 1. CDC guidance recommends screening of all persons entering the facility to include temperature checks, and completion of a questionnaire about symptoms and potential exposure. The CDC guidance further recommends enforcing social distancing between residents, ensure all residents wear a cloth covering for source control whenever they leave their room or are around others. Healthcare personnel should wear a facemask, at all times while they are in the healthcare facility. Refer to https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html.	{A 030}		

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{A 030}	Continued From page 16 upon arrival to facility and during the tour of the facility, observations were noted: A. On . . . at 8:30 a.m., Staff J Driver standing at front desk not wearing a mask. B. On . . . at 8:30 a.m. and on . . . . at 7:53 a.m., No temperature checks or completion of questionnaire took place at the time of entrance to the facility C. On . . . . at at 10:48 a.m., administrator confirmed that no screening took place upon arrival. He also said that he spoke to the staff and all told him that they were wearing masks. He confirmed that no resident is required to wear a mask. In a follow up interview with administrator on . . . . at 8:30 a.m., he said no one was here so early that is why no one was screening. He said he was supposed to be the one doing that and just came in. On at 8:38 a.m., another surveyor entered the facility. The administrator just took surveyor's temperature. No questionnaire was provided to be filled out. No questions were asked. D. Observation on . . . . at 8:45 a.m., revealed all hallway wall sanitizers were empty on west and east hallways upon arrival. E. Interview on at 3:15 p.m., the Secretary said the cook used to be responsible fill out the sanitizer wall dispensers. She quit last week. The Secretary said she told the housekeeper to go around and fill out the wall units. She said she will use what she has and will order more. They don't have any more. F. Observation on . . . . at 8:36 a.m. in the dining room, Staff Y was with residents and not wearing a mask or . . . covering. G. Observation on at 8:37 a.m. at the nursing station, revealed Staff L, Staff I, and Staff Z were observed to not be wearing a mask or covering. H. Observation over the 3 days of the survey	{A 030}		

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{A 030}	Continued From page 17 revealed a total of 41 residents were observed in varies parts of the facility. No resident was observed wearing a mask in the facility or social distancing. I. Interview on . . . . . at 10:21 a.m., Resident #12 said no one in the facility wears a mask, not even the staff, and no one has told her she should wear a mask when she is not in the bedroom or around others in the facility. J. Interview on at 8:15 a.m., Resident # 23 said no one ever wears a mask here. No residents or staff. No one told me to wear a mask. K. Interview on at 8:22 a.m., Resident # 24 said, "No I don't wear a mask. They do not wear one either, they put it on because you are here." L. Interview on . . . . . at 8:30 a.m., Resident #25 said "No we don't wear a mask. No one does. None of the staff wear a mask. They just put it on when the state comes in. We are ." M. Interview on . . . . . at 9:24 a.m., Resident #20 said, "No one ever wears a mask here. No resident ever wears a mask unless they go to the doctor. No staff wears a mask either. They just put it on now because the state is here." N. Observation on at 11:45 a.m., revealed Staff I was serving drinks to residents. Her cloth mask was bellow her . When she saw the surveyor she turned her . . . and placed her mask on her . She said she was never trained in COVID 19 or a mask wearing mandate." O. Observation on . . . . . at 11:50 a.m., revealed Staff BB with her cloth mask below her . She said she never received a training in COVID-19 or a mask wearing mandate. P. Interview on . . . . . at 12:30 p.m., the Administrator said he does not have COVID-19 and/or mask wearing related policies and procedures. He said he provided training to staff	{A 030}		

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{A 030}	Continued From page 18 and all were aware of what is expected them. 2. On review of facility's Adverse Incident Reports since the last survey the following was discovered: A. Incident date [illegible] - an event reported to law enforcement for investigation. Resident #20 had eloped from the facility. The facility's administrator filed an Adverse Incident Report because of police involvement and wrote in circumstances of the incident, Resident #20 had a diagnosis of [illegible], and the facility received a call from the police that Resident #20 was picked up at the corner store and they were bringing her to the facility. The sheriff was called by the store employees. The sheriff brought the resident to the facility. No education was done for current staff for elopement. B. Incident date - an event reported to law enforcement for investigation. The facility's Administrator filed an Adverse Incident Report because of police involvement and Resident #23 had eloped from the facility and wrote in the circumstances of the incident, Resident #23 who was diagnosed with [illegible] and declared [illegible] by the courts, had eloped from the facility and was seen at the corner store parking lot by staff on his way to work about 8:00 a.m. The sheriff department was called when staff went [illegible] to the corner store to bring the resident to the facility and Resident #23 could not be located. A search was organized. The police brought Resident #23 to the facility around 12:00 p.m. Staff were unaware of Resident #23's whereabouts until seen by a staff when driving to work. No staff education was done for current staff for	{A 030}		

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

elopement. Corrective action summary indicated all exit doors will be alarmed and kept always locked, and a guard will be attached to Resident #23's wheelchair which will trigger a separate alarm at the nursing station if he leaves the facility.

C. Incident date - an event reported to law enforcement for investigation. Resident #28 reported $1100.00 missing from his wallet. Police were called. The incident was reported to AHCA, but no investigation of the incident was done by the Administrator or his staff. No education was done for current staff on , neglect, and .

Interview on at 9:48 a.m., Resident #28, said he had just moved into the facility and 2 aides were assisting to put away his belongings and making his bed. He left the room and went to lunch and when he returned to his room and went to his wallet to go pay his rent, he found $1100.00 missing from his wallet. He states he told the staff and called the police and the aides that were in his room continued to work at the facility and the Administrator did not do anything about his missing money.

Interview on at 9:17 a.m., Resident Aide ( ) Staff H said when the residents file complaints and or staff report to the Administrator about complaints of missing monies, the Administrator tells them "he is not responsible and to call the police." Staff H states after the police is called no further investigation is done by the facility or Administrator. The staff involved in the allegations remain on duty at the facility on the schedule working, with no retraining for /neglect and , done for the current staff at the facility after the incidents.

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{A 030}	Continued From page 20 Interview on at 12:19 p.m., the Administrator said he was not aware he had to do any further investigation or education for staff after the above incidents. He said he thought after the police were involved, they would do the investigation. He said he was not aware the ARNP felt it was not safe to leave Resident #20 outside of the facility unsupervised. Class II .	{A 030}		
{A 165}	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. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints;	{A 165}		

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{A 165}	Continued From page 21 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 determine whether any of the incidents potentially	{A 165}		

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{A 165}	Continued From page 22 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 15 days of the incident. The full report must be	{A 165}		

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{A 165}	Continued From page 23 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 observation, record review, and staff and resident interview, the facility failed to ensure residents live in a safe, decent living environment free from . . . . . and neglect for 3 (Resident #20, #23 and #28) of 3 residents reviewed for adverse incidents. This is an uncorrected deficiency. The findings Included: On review of facility's Adverse Incident Reports since the last survey the following was discovered: A. Incident date . . . . . - an event reported to law enforcement for investigation. Resident #20 had eloped from the facility. The facility's administrator filed an Adverse Incident Report because of police involvement and wrote in circumstances of the incident, Resident #20 had a diagnosis of . , ... , and the facility received a call from the police that Resident #20 was picked up at the corner store and they were bringing her to the facility. The sheriff was called by the store employees. The sheriff brought the resident to the facility. No education was done for current staff for elopement. B. Incident date - an event reported to law enforcement for investigation. The facility's Administrator filed an Adverse Incident Report because of police involvement and Resident #23 had eloped from the facility and wrote in the circumstances of the incident, Resident #23 who was diagnosed with , ... , . . ,	{A 165}		

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{A 165}	Continued From page 24 and declared , by the courts, had eloped from the facility and was seen at the corner store parking lot by staff on his way to work about 8:00 a.m. The sheriff department was called when staff went to the corner store to bring the resident to the facility and Resident #23 could not be located. A search was organized. The police brought Resident #23 to the facility around 12:00 p.m. Staff were unaware of Resident #23's whereabouts until seen by a staff when driving to work. No staff education was done for current staff for elopement. Corrective action summary indicated all exit doors will be alarmed and kept always locked, and a guard will be attached to Resident #23's wheelchair which will trigger a separate alarm at the nursing station if he leaves the facility. C. Incident date - an event reported to law enforcement for investigation. Resident #28 reported $1100.00 missing from his wallet. Police were called. The incident was reported to AHCA, but no investigation of the incident was done by the Administrator or his staff. No education was done for current staff on , neglect, and Interview on at 9:48 a.m., Resident #28, said he had just moved into the facility and 2 aides were assisting to put away his belongings and making his bed. He left the room and went to lunch and when he returned to his room and went to his wallet to go pay his rent, he found $1100.00 missing from his wallet. He states he told the staff and called the police and the aides that were in his room continued to work at the facility and the Administrator did not do anything about his missing money.	{A 165}		

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{A 165}	Continued From page 25 Interview on [redacted] at 9:17 a.m., Resident Aide ( ) Staff H said when the residents file complaints and or staff report to the Administrator about complaints of missing monies, the Administrator tells them "he is not responsible and to call the police." Staff H states after the police is called no further investigation is done by the facility or Administrator. The staff involved in the allegations remain on duty at the facility on the schedule working, with no retraining for [redacted]/neglect and [redacted] done for the current staff at the facility after the incidents. Interview on at 12:19 p.m., the Administrator said he was not aware he had to do any further investigation or education for staff after the above incidents. He said he thought after the police were involved, they would do the investigation. He said he was not aware the ARNP felt it was not safe to leave Resident #20 outside of the facility unsupervised. Class III .	{A 165}		

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

(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
{CZ814}	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure all employees who provide direct care or have contact with residents or their personal belongings were screened and found eligible for employment prior to resident contact for 1 (Staff V) of 10 files reviewed. This has the potential for staff with disqualifying offenses to have access to adults. This is an	{CZ814}		

AHCA Form 3020-0001

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

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
	AL11942866	A. BUILDING: _____ B. WING _____	R 09/09/2021

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{CZ814}	Continued From page 1 uncorrected deficiency. The findings included: 1. Record review revealed Staff V was hired on /21 as a resident aide. Review of the Agency's clearinghouse employee roster revealed Staff V was added to the clearinghouse roster on /21. A background screening deemed him eligible on . Record review revealed Staff V was previously terminated by the facility on and there was more than 90 days gap from the last time he worked there. 2. Interview on at 12:45 p.m., the Administrator confirmed Staff V had being working in the facility since the date of hire on . The Administrator said Staff V was previously terminated on . The Administrator said Staff V was terminated as a result of a suspicion of stealing a cellular phone from a resident. The police completed their investigation and no charges ever pressed against Staff V. He said since he knew Staff V had a clear record he allowed Staff V to begin working in the facility on . He said he was not aware that he needed to re-screen and obtain the results for Staff V due to a 90-day break in employment. Unclassified	{CZ814}		