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
	AL11911412	A. BUILDING: _____ B. WING _____	R 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD PLAZA	15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A second revisit for a Change of Ownership survey and two compliant investigations (complaints numbered 2020019654 & #2020017280) and a second visit was conducted on [redacted] at Courtyard Plaza. There were deficiencies found at the time of the visit.	{A 000}		
A 010 SS=L	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

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A 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced	A 010		

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A 010	Continued From page 2 practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A ill resident who no longer meets	A 010		

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A 010	Continued From page 3 the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the appropriateness of continued	A 010		

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A 010	Continued From page 4	A 010		

residency for one out of forty-one sampled residents (Resident #33) who had a history of being verbally and physically [illegible] to residents and staff. Resident # 33 had three violent incidents from [illegible] to [illegible] and the facility allowed the resident to remain at the facility. Resident #33 threatened to [illegible] the facility down, threw a chair in the vicinity of other residents and assaulted three staff members.

Findings Included:

A review of Resident #33's health assessment completed on [illegible] showed a medical history and diagnoses of right occipital [illegible], atherosclerotic [illegible], and [illegible] of right [illegible]. According to the assessment, Resident #33 needed supervision in transferring and needed assistance with the self-administration of medications.

Incident#1

A review of the facility's emails between the Administrator and Resident #33's health care provider dated [illegible] stated, "please discharge him from Courtyard Plaza because he threatened to jump from the second floor and threatened to [illegible] down the facility.

A review of Resident #33's progress notes showed on [illegible]/202, the resident was sent to hospital for an evaluation due to behavioral issues. The notes stated that the resident threatened the Administrator, saying that he was going to jump from the second floor. Four days later, on [illegible], Resident #33 returned to the facility. There was no documentation that showed the resident was given a notice of

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A 010	Continued From page 5 discharge at this time nor documentation that resident was reassessed by a physician or that other interventions were implemented to prevent future reoccurrences. Incident#2 A review of the facility's records dated revealed Resident #33 threw a chair at the Administrator in the dining room, which was occupied by several residents who were eating dinner. The Administrator called 919 and the police arrived. A review of a police report dated on revealed," Upon arrival contact was made with the Administrator (Reporter) who advised that Resident #33 refused to take his medication, became irate, then threw the chair. A contact was made with Resident #33 who advised he was upset over missing property. Resident #33 took his medications in my presence and Administrator (Reporter) agreed to replace the missing property. The dispute was resolved." In an interview with the Administrator on at 11:26am, he stated Resident #33 was agitated; he asked the resident what was wrong, and then the resident threw the chair, which about 12 -24 inches in front of the Administrator. He stated he called 911. The administrator also stated the police officer told him that the resident said his (cellular phone) charger was missing and that was the reason he was upset. He stated he gave the resident $20 for the resident to buy a new cellphone charger, and the resident calmed down. A review of Resident #33's record showed no documentation of follow up with the resident	A 010		

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A 010	Continued From page 6 regarding the chair-throwing event. There was no documentation that the police were called as stated in the facility's resident , neglect, , policy and procedures. Incident#3 A review of the facility report dated on at 7:30am showed Resident #33 hit three staff members with a broom stick. The Administrator instructed Staff N (caregiver) to call Miami Dade Police. The police arrived at approximately 7:35am on Friday, , Miami Dade Police cuffed Resident #33 at approximately 8:20am. Residen#33 was taken to jail. A review of a police report dated at 7:28am, showed the police were called and arrived at the facility due to an alleged aggravated battery. The police office report revealed," Upon arrival, I made a contact with Victim #1(Staff C) who explained she was in the hallway near the laundry room, getting ready to do laundry, when the (Resident #33) came trying to enter the laundry room. Victim #1(Staff C) told the resident he was not allowed in the laundry area. The (Resident #33) became upset and engaged in an argument with Victim # 1. Victim #1 ignored the resident the (Resident #33), the became physical, he walked up to her, slapped her with an open across the , and then left the area. He then kicked Victim #1 (Staff C) in the while she was on the floor picking up clothes off the floor. Later, the (Resident #33) returned to the scene and kicked the staff. Resident #33 was and charged with two counts (Felony and misdemeanor) for aggravated battery."(Sic) A review of the facility's video camera footage	A 010		

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A 010	Continued From page 7 showed on . . . . . between 7:21am- 7:28am Resident #33 assaulted three staff members by slapping, punching, kicking, and hitting the staff with a broom and dust pans for approximately 7 mins (7:21AM- 7:28AM) while four other residents were within 3 of the event. A further review of the video footage also showed one resident was in a wheelchair and was observed covering his with both arms to shield himself from the possible assault. A second resident, using a walker to ambulate, was observed trying to move away from the scene. A third resident was observed trying to assist the staff, then trying to walk away from the incident during the Resident #33's third round of assaults with the objects. In an interview with Staff C (Home Health Aide) on at 12:18pm, she stated she was in the laundry area, when Resident #33 went into the laundry room, she told the resident that he was not allowed in the laundry room. She stated the resident became irate, aggressive, and started cursing at her. She stated regarding Resident," He picked up a broom from the cleaning cart and . . . . . me. He hit me with the broom, kicked and punched me. He hit [Staff F] (housekeeper). She stated, "After the incident, I went to the hospital because I had a and a . . . . . ." She stated," I have to go to , , every week". In an interview with Staff F on /2021at 12:12pm, she stated she saw Resident #33 . . . . Staff C, and she tried to stop the resident from hitting Staff C. She also stated," I told him to stop hitting her. He hit me with the broom and punched me."	A 010		

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A 010	Continued From page 8 In an interview with Staff C and F on [redacted] at 2:12pm, both staff members stated they didn't receive training at any time before or after the incident on resident de-escalation or how to deal with an aggressive resident. In an interview with an eyewitness (Resident #42) on [redacted] at 12:40pm, she stated I don't know why he acts like that. He's always aggressive and cursing at the resident and staff. I stay out of his way. I heard he threw a chair one time". In a further interview with an eyewitness (Resident #42) on [redacted] at 1:15pm, she stated Resident #33 went to laundry area, he started yelling, cursing out the staff, and acting "out of control". He picked up the broom and started hitting staff. She stated," He was acting crazy until the police arrived, then calmed down. The police [redacted] him. In an interview with Resident #12 (another eyewitness) on [redacted] at 2:27pm, he stated he heard Resident #33 yell "My clothing is missing" before assaulting the staff. Further review of Resident #33's progress notes dated on [redacted], Resident #33 was taken to the county jail for altercation with staff. In an interview with the Administrator on [redacted] at 2:49pm, he stated he had already issued a 45-day notice to Resident #33 on [redacted], before the assault on [redacted] due to the resident being verbally [redacted] to other residents and refusing to wear his mask in common areas. He also stated as a preventive measure he implemented a two-hour checklist to ensure employees are observing the resident	A 010		

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A 010	Continued From page 9 every two hours. He also stated he hired four new employees to assist and provide supervision. He also stated he hired two additional staff for the activities department and two additional staff were hired to the Nursing Department to help supervise and assist the residents. Class I	A 010		
{A 025} SS=L	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of ... or ... or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such ... or ... The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making ... for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal	{A 025}		

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{A 025}	Continued From page 10	{A 025}		

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 record review and interview, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being of two out of 45 sampled residents (Residents #43 and #44). Resident #43 eloped from the facility and had not been located at the time of the survey. Resident #44 eloped within two months of arrival at the facility. The facility failed to implement measures to avoid the repeat elopements of residents with a

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{A 025}	Continued From page 11 history of . . . . The facility failed maintain a written record for two out of 45 residents {Resident #43, #44}. Findings include: 1) A review of a facility incident report dated showed that at 5:30 PM on . . . . . , Staff P (Medication Technician) notified the Director of Resident Services and the Administrator that Resident #43 was missing. The report stated that the facility initiated its elopement protocol, and a was search was conducted at an unspecified time. The police were then contacted by the Director of Resident Services and a missing person report was completed. A review of Resident #43's progress notes dated showed, "At date shown Administrator and [Director of Resident Services] notified by facility staff that resident is not in the facility." In an interview with Staff P, Medication Technician on . . . . . at 11:57 AM, he stated, "I asked the CNA staff for [Resident #43] in the morning time around breakfast, but no one could give me an answer. Sometimes he will show up late for breakfast and lunch, but he didn't show up at all that day. In the afternoon, I asked the CNA staff again, and no one knew where he was. He didn't take his medication the whole day. I then decided to look for him in his room, but he was not there. At 5:30 PM, I called the Director of Resident Services and the Administrator to let them know that [Resident #43] was missing." In an interview on at 1:32 PM, Staff U (caregiver) stated she worked on from 11 PM- 7 AM and last saw Resident #43 at 5	{A 025}		

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{A 025}	Continued From page 12 AM on . A review of the facility's 2-hour monitoring log for Resident #43 dated . was shown to be blank. A review of the police report filed on . showed that the facility contacted the police at 8:13 PM about "a missing person." The Director of Resident Services informed the officers that at approximately 5:18 PM, Resident #43 left the facility without notifying staff or signing the facility's sign-out sheet and has not taken his medication since . A review of the facility's elopement policies and procedures showed that "the preliminary inside search efforts should last no longer than minutes. If the resident is not found, the facility expands the search to side streets and main roads lasting no more than minutes. If the resident is not found, law enforcement is to be called. Family members or, in the absence of any family, other responsible people will be notified by the Administrator or designee after the preliminary search and within one hour or less of determining that the resident has eloped or is missing." A review of Resident #43's progress notes showed no documentation that the resident's case manager was contacted. A review of Resident #43's record showed he was admitted on . The health assessment completed on showed a medical history and diagnoses of of type, , , and a history of COVID-19 . The resident was independent with ambulation, , , eating, self-care, toileting, and transferring and	{A 025}		

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(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 025}	Continued From page 13 needed medication administration. The health assessment documented that the resident was not an elopement risk at the time of admission. During an interview on . . . . . at 1:55 PM, Resident #43's case manager from the State Hospital stated that she oversaw the resident's care while he was a patient at the hospital for the past two years. Regarding Resident #43's elopement, the case manager stated, "It doesn't surprise me that he did something like that." A review of Resident #43's record showed his discharge documentation from the State Hospital where he resided before being admitted to the facility showed the resident was 'refusing placement in an assisted living facility because he has his mansion and there are " and vampires" residing in the ALFs.' In an interview on . . . . . at 10:43 AM, when asked if the facility reviewed the documentation from Resident #43's discharge from the State Hospital, the Director of Resident Services stated, "No, because when he was here, he didn't show that type of behavior." During an interview with Resident #43's case manager on . . . . . at 12:16 PM, he stated, "I was assigned to [Resident #43] for 30 days after he was discharged from the State Hospital. As of yet, the police have not been able to locate him." 2) A review of the report filed by the facility regarding the incident showed that on at 11:30 PM, Staff U, CNA, and Staff V, HHA, discovered while conducting room checks Resident #44 was missing from his room. Staff conducted a room search and discovered three	{A 025}		

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{A 025}	Continued From page 14	{A 025}		

bedsheets tied together hanging outside his second-floor window. The facility then initiated its elopement protocol and notified the Director of Resident Services and the Administrator that the resident was missing. At 11:57 PM, the facility received a call from Resident #44's mother stating that the Resident had arrived at her home. The resident's mother contacted the police, and the resident was [redacted] at 1:09 AM.

On [redacted] at 1:32 PM, Staff U stated, "I worked from 11 PM to 7 AM. The first time he eloped, I was working on the side he was. I called [the Director of Resident Services] and told her I didn't see him. It was around 11 PM. I don't know what time he left because we're supposed to open the doors to see what the residents are doing at night. I came to work at 11 PM. When I checked his room and saw he wasn't there, I called the supervisor right away. I saw there were many sheets tightened together to make a rope. They were on the window. It was on the 2nd floor. He tightened them together, made a rope, and escaped through the window."

A review of the facility's 2-hour monitoring log for Resident #44 dated [redacted] showed it was last completed at 9 PM.

A review of Resident #44's progress notes showed no documentation of the resident eloping from the facility.

On [redacted] at 12:48 PM, when asked why there were no progress notes of Resident #44's elopement, Staff B stated, "I don't think he eloped in [redacted]."

On [redacted] at 12:59 PM, Staff B (caregiver) retracted her statement and stated, "[Resident

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#44] went straight to his mother's house, and she called the police. She had a stay-away order against him. I don't know how long he was missing. He was missing for a few hours. From the [jail], he went to the Behavioral hospital."

A review of Resident #44's record showed he was admitted on . The health assessment completed on showed a medical history and diagnosis of , . The resident was independent with ambulation, eating, self-care, toileting, and transferring and needed assistance with self-administration of medications. The health assessment documented that the Resident was not an elopement risk at the time of admission.

During an interview on at 11:53 AM, when asked what preventive measures were put in place after Resident #44's first elopement, the Administrator stated, "The facility implemented 30-minute checks, and in-service training was completed with all employees about the change of status."

A review of Resident #44's records showed no documentation of 30-minute monitoring after his first elopement. Further review of Resident #44's records showed no documentation of the resident being reassessed after the elopement.

On at 1:01 PM, when asked whether Resident #44 was assessed by a medical provider after the first elopement, Staff B stated, "No, [Resident #44]'s case manager was trying to get him a doctor's , , at a [non-profit organization] because he didn't have any insurance."

On at 1:07 PM, Staff B stated that

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{A 025}	Continued From page 16 after Resident #44 eloped, his room was switched to an interior room in view of cameras. A review of the adverse incident report filed by the facility showed on [redacted] at 12:53 AM, Staff V (home health aide) informed the Director of Resident Services that Resident #44 was missing from his room. The Director of Resident Services then contacted the Administrator at 1 AM. The facility then initiated their elopement protocol, but the resident was not found, and the police were notified. Resident #44 was found near his mother's home and then transferred to the crisis unit at the hospital. In an interview with Staff V on at 3:47 PM, she stated, "When I went to check [Resident #44]'s room, I saw the bedsheets tied together and went to the window. When I came and saw the bedsheets at the window, I called the Administrator right away. I didn't find him; then I called the manager." A review of Resident #44's progress notes dated [redacted] showed, "Resident went out from his bedroom window in the middle of the night. At 7:40 AM on [redacted], Staff N (caregiver)contacted me to let me know [Resident #44] eloped. I called his case manager to let her know at 7:41 AM the same day. [Resident #44]'s mother told me that [Resident #44] was at her house, and she did call the police. I told her I was on my way. When we got there [Staff B, Staff P, and Staff Q], [Resident #44] wanted to hit me, so we moved the car up the street more. I called his mom, and she asked me to call the police for her again so they could come faster. I did, and they showed up and took him to [hospital] crisis unit." On at 1:15 PM, when asked who	{A 025}		

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{A 025}	Continued From page 17	{A 025}		

wrote Resident #44's progress notes on his elopement, Staff B, stated, "I did. When I found out he was at the mother's house, I called the case manager and told her that the resident was at his mother's house and that he violated the stipulations of their agreement and would not be allowed . . . to the facility. Me and [Staff P] went to the mother's house. His mother called me to call the police again because she needed them to come faster. We only came to lay , on him, not take him . . . . The police came and picked him up." (Sic)

In an interview with the Administrator on . . . . . at 9:15 AM, he stated, "[Resident #44] made several remarks about , telling him to leave. [Resident #44] attended several meetings with his case manager. He would return to the facility very agitated."

A review of Resident #44's progress notes showed no documentation that the facility contacted the Resident's case manager about the resident's thoughts of leaving or to seek guidance on preventing further occurrences.

During an interview on at 10:45 AM, Resident #44's case manager stated, "[Resident #44] became my ward through the mental court. He has been and hospitalized numerous times, and because of that, the courts decided to place him in an assisted outpatient treatment program for people with mental illness. He did come into the program , , . Right now, he is still hospitalized at the behavioral hospital." When asked whether the facility informed her that Resident #44 had thoughts of leaving the facility, she stated, "They didn't tell me about nothing like that. He seemed to be okay after we adjusted his medication."

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{A 025}	Continued From page 18 Class I	{A 025}		
A 028 SS=D	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to turn and reposition one out of 45 sample residents (Resident #45) leading to a [redacted]. Finding include: A review of [redacted] Source (www.[redacted].com), pressure injuries are localized areas of tissue necrosis that typically develop when soft tissue is compressed between a bony prominence and an external surface for a long period of time. [redacted] pressure injuries are characterized by superficial reddening of the skin that when pressed does not turn white (non-blanchable [redacted]). If the cause of the injury is not relieved, these will progress and form proper [redacted]. A review of the Resident #45 Health Assessment dated [redacted], it showed that the resident had a Medical History and Diagnosis of: [redacted] without [redacted], benzodiazepine dependence, [redacted], hearing loss, tremor, [redacted], nephrolithiasis ([redacted]),	A 028		

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A 028	Continued From page 19 , and unable to walk. The resident was wheelchair bound. The resident required prevention. As for activities for daily living, the resident required assistance with all her ADLs (ambulation, bathing, , eating, self-care, toileting, and transferring). The examining physician also indicated in the Health Assessment that the resident did not have any , 3, or 4 , . A review of Resident #45 facility Admission Sheet dated , the admission sheet indicated that the resident skin did not have any , , scars, rashes. The admission sheet also indicated that the resident required a wheelchair for ambulation and that it required with transferring. A review of Resident #45 Observation Log dated , it showed that Staff L reported skin redness in the area. A review of Resident #45 Resident Skin Sheet dated on , Staff L documented that the resident had redness in the area. There was no documentation of any follow-up or intervention. A review of Resident #45 Resident Skin Sheet dated on , Staff L documented that the resident had redness in the area. There was no documentation of any follow-up or intervention. In an interview with Staff M on at 10:47 AM, Staff M stated that Resident #45 developed only skin redness around the area. The skin was always intact. In interview with Staff A on at 11:45	A 028		

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A 028	Continued From page 20 AM, Staff A stated that Resident #45 did not have a , , or a , in the area. He also stated that there was no redness on the resident heels. In an interview with on at 8:22 AM, Staff M stated that Resident #45 only had skin redness. The skin was intact. She first found out about the skin redness on . The last time I saw the resident on , the resident continues with skin redness and the skin was intact. As for the care the resident received, the C.N.A (Certified Nursing Assistant). helped the resident with her activities of daily living each day. As for repositioning the resident every 2 hours, Staff M stated that she was not sure if it was provided by the C.N.A. Class III	A 028		
{A 030} SS=J	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary 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	{A 030}		

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{A 030}	Continued From page 21 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. 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	{A 030}		

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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 [redacted] 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 [redacted].

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 [redacted] 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

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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 medications, assistance in making [illegible]
for health care services, the provision of or arrangement of transportation to health care [illegible], and the performance of health

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{A 030}	Continued From page 24 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 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	{A 030}		

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prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and, if applicable, ... , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . , ... 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

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(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 030}	Continued From page 26 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 interview, the facility failed to honor the residents' right to live in an environment free from . . . . . and neglect for one out of forty-one sampled residents (Resident #45). Resident #45 was physically assaulted by another resident, sustained an injury to his left . . . . . , 911 was called and the resident was transferred to the hospital. Findings Included: 1) A review of the facility's adverse incident report dated showed, Resident #45 was hospitalized after being assaulted by Resident #1. The report revealed, (Resident #45) was in the recreation room located on the 1st Floor of the facility and another resident (resident #1) pushed him and he . . on the floor. Resident #45 sustained an injury to his left . Staff called 911 and the paramedics arrived approximately 10:23AM and transferred the resident to the emergency room. Further review of the facility's incident report showed the other resident (Resident #1) was transferred to the hospital behavioral unit at approximately 10:30am on . . . . Fifteen days later, the Administrator later learned the residents were having a dispute about a chair in the recreation area. A review of Resident #45's health assessment	{A 030}		

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	AL11911412	A. BUILDING: _____ B. WING _____	R 10/06/2021

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{A 030}	Continued From page 27 dated showed a medical history and diagnosis of , , , , , , rhabdomyolysis, D deficiency, , , , , and . The resident needed assistance in bathing, , self-care (grooming) and self-administration of medications. A review of Resident #45's progress note dated showed, 'resident went to the hospital for observation, no concerns at the time.' Review of another progress note dated showed, 'Resident had returned to the facility from the hospital.' Review of resident #45 record found no documentation as to why resident was sent the hospital and no documentation a resident-to-resident altercation had occurred. In an interview with the Administrator on at 2:45pm, he stated after the assault, Resident #45 suffered a left injury and was transferred to the hospital for observation. He stated Resident #1 was sent to the hospital and placed on a , in-patient unit. In an interview with Staff N (Medication Technician) on /2021at 2:49pm, she stated she was working on the day of the incident. She stated both residents (Resident #45 and #1) were walking through the door in the recreation area. Resident #1 pushed Resident #45. Resident #45 lost his balance, on the floor, and injured his . In a second interview with the Administrator on at 11:19am, he stated resident's #45 and #1 returned to the facility. He stated as a preventive measure, he instructed staff to supervise both residents and to ensure they keep apart from each other. He stated he also hired	{A 030}		

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{A 030}	Continued From page 28 two additional staff in the activities department to help supervise and assist the residents when doing activities. A review of Resident #1's health assessment completed on showed a medical history and diagnoses of [illegible] pemphigus, foliaceus second to [illegible]-sensitive staph [illegible]. The resident needed assistance with self-administration of medication. A review of Resident #1's record found no documented follow up or intervention to prevent resident from assaulting other residents when the resident returned from the hospital. A review of Resident #1's hospital record dated on showed," 55 yr. old male with [illegible]. He stated he pushed a man. Patient requires place. Social worker was contact however did not answer. Patient needs to be a admitted into a new ALF". Review of the facility record found no documented intervention after Resident #1 assaulted Resident #45. A review of Resident #1's hospital record dated on showed the resident was transferred to the hospital due to an altercation with another resident. There were no concerns. The patient's social worker was contacted multiple times but could not be reached. A review of emergency department physician's notes showed that Resident #1 pushed Resident #45 because the other resident was not moving while he was in front of him, this made him upset him, so he pushed Resident #45. He also noted, "Patient requires placement to a new nursing home. The patient's social worker was contacted	{A 030}		

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{A 030}	Continued From page 29	{A 030}		

multiple times, unable to reached. Patient needs to be admitted for placement into a new nursing home. "Review of the facility record found no documented intervention after Resident #1 assaulted Resident #45. (sic)

A review of Resident #45's hospital discharge summary dated showed the resident was discharged from the hospital with AC , (Acromioclavicular ,)) and , . According to Mayo Clinic, "AC , separation or separation, occurs when the separates from the . . . , . . . It is commonly caused by a directly on the . The injury may stretch."

Review of the facility's record dated on . . . . . showed the facility was previously cited for resident rights regarding resident-to-resident . A resident was assaulted by another resident at the facility on . . . . . , acquiring two black , and a broken after . . . . , into the other resident's room unsupervised by staff. The facility implemented a plan of correction . . . . . to prevent future occurrences. A review of the facility's plan of corrections revealed," To ensure a safe environment for all residents, the facility has introduced a program to thoroughly evaluate all residents' behavior. We have increased support groups to ensure the behavioral wellbeing for the residents. The goal of the program is to closely monitor all residents' behavior and document any changes as seen by staff. Staff will notify medical professional in the event of any unforeseen changes in behavioral wellbeing. The facility will also have a certified social worker visit the facility frequently and work with the residents in all areas to ensure they have proper care.

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{A 030}	Continued From page 30 A review of the facility bill of rights revealed the facility agreed to ensure all residents would live in a safe and decent home free from . . . . . and neglect. The policies further stated the facility would discharge any resident who physically assaulted a resident. However, the facility allowed Resident #1 to return to the facility. A review of the facility's record showed staff completed a one hour in- service training from the Administrator on . . . . . titled "Recognizing indicators/signs and . . . changes with residents for timely intervention and skin observation/documentation forms." In an interview with Staff C (Home Health Aide) and F (Certified Nursing Assistant) on . . . . . at 2:12pm, both staff members stated they didn't receive training at any time before or after the incident. Class I	{A 030}		
A 032 SS=E	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A	A 032		

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A 032	Continued From page 31 resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case	A 032		

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A 032	Continued From page 32 manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(i), F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to follow its policies and procedures regarding elopement when two out of 45 sampled residents eloped from the facility (Resident #43, #44). Resident #2 had a history of elopement, and no interventions were implemented to prevent further elopements. Findings include: A review of the police report filed on showed that the facility contacted the police at 8:13 PM about "a missing person." The Director of Resident Services informed officers that at approximately 5:18 PM, Resident #43 left the facility without notifying staff or signing the sign-out sheet and has not taken his medication since . A review of Resident #43's record showed he was admitted on . The health assessment completed on showed a medical history and diagnoses of of type, , and a history of COVID-19 . The resident was independent with ambulation, , eating, self-care, toileting, and transferring and needed medication administration. The health assessment documented that the resident was	A 032		

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A 032	Continued From page 33 not an elopement risk at the time of admission. A review of the facility's elopement policies and procedures showed that "the preliminary inside search efforts should last no longer than minutes. If the resident is not found, the facility expands the search to side streets and main roads lasting no more than minutes. If the resident is not found, law enforcement is to be called. Family members or, in the absence of any family, other responsible people will be notified by the Administrator or designee after the preliminary search and within one hour or less of determining that the resident has eloped or is missing." A review of Resident #43's progress notes showed no documentation that the resident's case manager was contacted. A review of the facility's elopement policy showed that "Prior to resident's admission to the facility an ALF representative conducts a pre-admission evaluation in order to determine whether the resident is appropriate for admission. This evaluation includes the resident's status regarding risk of elopement." A review of Resident #43's record showed no documentation of a pre-admission evaluation completed on the resident. During an interview on at 10:15 AM, when asked if the facility conducts a pre-admission evaluation of the residents before admission, the Director of Resident Services stated, "No, not anymore. We used to do that a long time ago." Class II	A 032		

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A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and chapter 483, part I, F.S. A valid copy of the State Clinical Laboratory License, if required, and the federal CLIA Certificate must be maintained in the facility. A state license or federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the State Clinical Laboratory License and federal CLIA Certificate is available from the Laboratory Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32,	A 053		

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A 053	Continued From page 35 Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a staff member license to administer medications for one out of 45 sample residents (Resident #45). Finding include: A review of the Resident #45 Health Assessment dated [redacted] showed that the resident had a Medical History and Diagnosis of: [redacted] without [redacted], benzodiazepine dependence, [redacted], hearing loss, tremor, [redacted], nephrolithiasis ([redacted]), [redacted], and unable to walk. The resident was wheelchair bound. The resident required [redacted] prevention. As for activities for daily living, the resident required assistance with all her ADLs (ambulation, bathing, [redacted], eating, self-care, toileting, and transferring). As for medications, the resident required medication administration. A review of Resident #45 Medication Observation Record (MOR) from [redacted] to [redacted] showed that the resident was prescribed, and the Medication Technician administer the following medications: 1. [redacted] 20 mg take one capsule by daily 2. [redacted] Moisturizing Lotion apply twice a day 3. [redacted] 75 mg take one tablet by daily 4. [redacted] 0.25 mg take one tablet by twice a day 5. [redacted] 20 mg take one tablet	A 053		

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A 053	Continued From page 36 by . . . at bedtime 6. 100 mg take one tablet by . . . twice a day 7. 500-unit apply a thin layer to the . . . . . area three times a day. 8. , 500 mg take two tablets by . . . daily as needed for , . . In an interview with Staff A on . . . . . at 10:30 AM, Staff A stated that "there are no License Practical Nurses (LPN) or Registered Nurses (RN) on staff". In an interview with Staff M on at 10:47 AM, Staff M stated that there were no License Practical Nurse or a Registered Nurse on staff. Resident #45 medications were administered by the medication technician. The medication technician is a non-license staff member. Class III	A 053		
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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A 152	Continued From page 37 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 [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [illegible] 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 ensure that all existing architectural, mechanical, electrical, and structural systems and appurtenances maintained in good working order. Finding include: Observation on [illegible] at 8:45 AM during a facility tour showed missing ceiling tiles in the second hallway of the second floor. Observation on [illegible] at 8:55 AM showed dark spots surrounding damaged drywall on the	A 152		

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A 152	Continued From page 38 ceiling of . . # . On . . . . . at 9:35 PM, the Director of Resident Services stated she would have maintenance look into everything discussed. Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a . . ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but	A 160		

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A 160	Continued From page 39 intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . . . . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related . . . . . , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40,	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911412	A. BUILDING: _____ B. WING _____	R 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD PLAZA	15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 40 F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log for one of 45 sampled residents (Resident #45) Finding include: A review of the facility Admission and Discharge Log on , it showed that Resident #45 was admitted to the facility on . The Admission and Discharge log did not document when the resident was discharged from the facility. In an Interview with Staff A on at 9:00 AM, Staff A stated that the resident was discharged from the facility on .	A 160		

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
	AL11911412	A. BUILDING: _____ B. WING _____	R 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 160	Continued From page 41 Class III	A 160		