Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953671	A. BUILDING: _____ B. WING _____	R 01/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments Amended A third revisit to a Change of Ownership and a Complaint Investigation (Complaints #2021001948 and 2021005856) was conducted at Grand Court Lakes from . . . . . to . . . . Deficiencies were identified at the time of the survey.	{A 000}		
A 004 SS=L	59A-36.004 FAC Licensure - Requirements (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in rule 59A-36.005, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in rule 59A-36.005, F.A.C. (4) CONTIGUOUS PROPERTY. If a facility	A 004		

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A 004	Continued From page 1 consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of chapters 408, Part II, 429, Part I, F.S. and rule chapter 59A-35, F.A.C., and this rule chapter. (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to chapter 408, part II, and section 429.14, F.S., and rule chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to notify the Agency for Health Care Administration that it had changed the use of space and decreased the facility's capacity. Fifty two people who the facility did not regard as assisted living facility residents were moved into licensed beds. Among the non-residents moved in, a occurred onsite.	A 004		

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A 004	Continued From page 2 Findings: A review of facility records showed that it gained approval for a bed capacity expanison in . . , ... , 2020, bringing the licensed Assisted Living Facility beds to 191. Further review showed photographic evidence of units in building B approved under the bed capacity expansion. Observation on through found 63 residents receiving care and services. Further observation revealed that an additional 52 residents were living onsite in licensed assisted living beds in building B. Interviewed on at approximately 8:00 am, the Administrator stated that she was concerned about the use of space onsite. She said there were several facility beds which were occupied, but which she did not have access to since she had started as the administrator a few days earlier. She further stated that a had occurred onsite in . . . . . , 2021 in a unit that was licensed, approximately three days before she was hired on as the Director of Nursing. She stated that Resident #36 had been "decapitated" by his lover. She further stated that there had also been a lot of drug and use, assaults, and other crimes at the facility, most occurring in 'Building B', which the owner told her was not licensed, but was instead independent, and had been rented out in collaboration with a company which housed the homeless. The Administrator stated that she was concerned for the safety of residents in buildings C and D, where and frail elderly were housed. She said the residents had been consolidated into these two areas so that staff could easily reach them, because of the reduction in census brought about by the facility's moratorium on	A 004		

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A 004	Continued From page 3 admissions. She stated that she was most concerned about Resident #37, who was the only resident living in building C because she refused to move out of her unit. The Administrator stated that there were no barriers or locks preventing residents from building B from coming to building C and [redacted] Resident #37 without staff knowledge. She stated that she had increased staff's supervision of Resident #37 to try to protect her. A review of facility and agency records showed no documentation that the change in use, the occupancy of building B by residents not considered to be a part of the assisted living facility, was reported to the Agency for Health Care Administration. Further review found no documentation of resident contracts onsite for the residents of building B. Interviewed on [redacted] at approximately 9:30 am, the Maintenance Director and the Administrator were unable to provide any information about the 52 residents in building B. Several requests for access to inspect the units in building B were denied. At approximately 12:40 pm, the Director of Operations provided some leases with residents of building B. The remaining leases were provided two days later, on [redacted]. A review of leases obtained from the property Owner documented that the 52 residents in building B had signed the agreements with the Owner. Observation of Building B on [redacted] revealed that the maintenance staff did not have access to any of the units. When asked to obtain keys so that the rooms could be inspected by state	A 004		

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A 004	Continued From page 4 representatives, the Maintenance Manager obtained one key and stated that he had been threatened with termination if he took any other key. He stated he had also been told that the Agency for Health Care Administration had no access to these units. Further observation revealed that all units except B310 were occupied. The Maintenance Manager stated that many of the residents were 'crazy', and that one or two of them were aggressive and had threatened to kill him on several occasions. He stated that he was not allowed to access these units and that the owner had a separate property management team which ran the building. Observation revealed that the Maintenance Manager asked Staff N (maintenance person), who was employed by the other company, to open the units where residents did not answer the door. Observation of access areas between building B and C/D on and revealed a locked gate on the ground floor, which could only be opened by maintenance staff who had a code. Further observation revealed that state representatives accompanied the Maintenance Manager from Building C/D to building B by taking the elevator. The group exited the building on the fourth floor and walked across to Building B. There were no barriers preventing access to or from building B on the second, third, fourth or fifth floors. Observation of the distance between Resident #37's unit in building C and building B was approximately 500 (photographic evidence obtained). Interviewed on , the Maintenance Director stated that residents from Building B used the elevators and the stairs to go to buildings C and D, however he did not describe	A 004		

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A 004	Continued From page 5 why building B residents needed to access Buildings C and D. A review of facility records and the incident report database showed no documentation that the facility reported Resident #36's . A review of autopsy reports showed that Resident #36 was at 3:00 am in unit B310 by his domestic partner on . According to the fire rescue and autopsy reports, "on , Miami-Dade Police officers responded to the residence [ ], in reference to a report of a violent verbal dispute. The decedent was involved in an argument with his live-in boyfriend. The argument then became physical and the decedent was stabbed multiple times. Upon police arrival to the apartment, the decedent was discovered unresponsive in his bedroom lying in a pool of with a knife near his body. Emergency medical services were summoned. [ ]Fire Rescue was dispatched and responded to the scene under incident and pronounced her (sic) on the scene. According to the rescue report, he was found lying prone on the bedroom floor. The decedent's , and , were absent. He had a across his . He was also , with signs of rigor to his upper extremities. He was pronounced upon arrival by fire rescue personnel at 6:49 a.m." Regarding the evidence of injury, the medical examiner's report stated, "This stab penetrates through skin, fat, and of the , -lateral aspect of the left side of the and enters the , canal between the third and fourth transecting the , cord. Associated with this stab is , , and , cord . The stab	A 004		

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A 004	Continued From page 6	A 004		

. . . . extends to an approximate depth of 8 cm. The knife blade is 10 x 2 cm in dimension."

On at 1:50 PM Building B resident #38 stated "When I came to live here, there was nobody. The police came because they killed someone in 310, that guy used to work here before cutting the grass. There are thousands of problems here. There is a lot of drug use here. Time ago I left my door opened and someone entered and stole my purse with $370. I forgot to lock the door. I think he was stabbed like 32 times. The guy that stabbed him, used to live before on the fifth floor with his mother, who got evicted. There was a restriction (sic) order against him. They said there were drugs in the apartment. We never go to the other side of the building. I never go downstairs because there are a lot of drunks and people using drugs. All men and women use drugs."

On at 8:39 PM Staff U stated, "Daytime is fairly normal, but at night I see a different behavior on that side. I don't know where they come from. I don't know if it is drugs, but these people are weird."

A review of calls to service records from Emergency Services (Police/Fire/Medical) revealed that there were 161 calls to service at the facility's address between . . . . and . . . . , including 7 burglaries, 4 larcenies, 10 assaults, 46 disturbances, 3 missing persons, 5 persons on arrival and 3 . . . . . investigations.

On . . . . . at 9:16 AM Resident # 66 stated. "I know about a that happened in the other building. I personally don't like it here anymore. It is getting worse by the day. This place was not

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A 004	Continued From page 7 bad before, sometimes they don't even have juice or butter for the bread, they say they ran out." On at 9:27 AM Staff DD, activities director, stated that she did not feel safe at the facility and found out about the through a co-worker. Staff DD further stated that the facility declined, and there was no security. She stated, "the independent living residents go upstairs and walk through the corridor and have access to the assisted living facility residents." On at 9:43 AM the Security Company Owner stated, "I have a contract with Grand Court Lakes since 2014 and only provide service for the overnight shift from 11:00 PM-7:00 AM. The security is only on the front desk and looking at the cameras. I was not informed of any and have not make any changes to the security. There are gates to get into the parking lot and on the first floor to go to the other buildings the gate has a code. Also, on the other floors there are gates with code. I go there every Monday to pay the security guard, but I do not go inside." Class I	A 004		
{A 025} SS=I	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification	{A 025}		

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{A 025}	Continued From page 8 must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) 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	{A 025}		

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{A 025}	Continued From page 9 resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for one out of sixty-three residents. Resident # 13 eloped from the facility and returned 3 days later with a black Findings Included: During an inspection on the morning of the Administrator stated that Resident #13 had gone out the day before and had not returned. She stated the facility did not no where he was going, but that she believed he used to go and see a romantic partner. A review of Resident #13's health Assessment completed on showed Resident had medical history and diagnoses of Prostatic Hyperplasia, Hx (history) of Congenial Subglottic Overactive , Hx of , of vocal Hx of . The resident was described as "NO" elopement risk; The resident was independent with all activities of daily living including ambulation, bathing, , eating, grooming, toileting, and transferring. The resident	{A 025}		

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{A 025}	Continued From page 10 needed assistance with self-administration of medications. On Record review revealed Resident #13's health assessment had not been updated since his return to the facility on A review of Resident #1's medication observation records (MOR) showed Resident #13 missed the following medications on thru : According to the US National Library of Medicine: D3 1000 1 capsule once daily 9:00 a.m. Missed dosage on , 13th, 14th, 2022 Is used as a dietary supplement in people who do not get enough D in their diets to maintain adequate health D2 50,000 IU, 1 capsule once a week, 9:00 a.m. Missed dosage on , Is used to treat and prevent , Therapeutic (Therems) tablet, 1 tab once daily, 9:00 a.m. Missed dosage on and 14th, 2022 Is used to treat deficiencies, lack of may cause illness, poor nutrition, , and many other conditions. 12% Lotion, apply , , on skin Once daily 9:00 a.m. Missed dosage on and 14th, 2022 Is used to treat dry, scaly skin. Indicated to treat itching caused by dry skin. Ensure Enlive strawberry Drink one bottle by as directed (twice daily) 9:00 a.m. and 5:00 p.m. Missed dosage on and 14th,	{A 025}		

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{A 025}	Continued From page 11	{A 025}		

2022
Is used as a nutritional supplement.

500 mg, take 1 tablet by
twice a day, 9:00 a.m. and 5:00 p.m. Missed
dosage on and 14th, 2022
Is used together with diet and exercise to improve
control in adults with type 2

20 mg, 1 tablet twice a day, 7:00 a.m.
and 4:00 p.m. Missed dosage on and
14th, 2022
Is used to treat and prevent in the
and

tart 25 mg 1 tablet twice a day, 9:00
a.m. and 5:00 p.m. Missed dosage on
and 14th, 2022
Is used to treat , and high
. It is also used to lower your risk of
or needing to be hospitalized for
. If not taken as prescribed, it could raise
your chances of a a ,
, or other complications.

2 % Cream (30G 2%
cream) Apply , to nails twice daily, 9:00
a.m. and 5:00 p.m. Missed dosage on
and 14th, 2022
It is used to treat certain caused by

Prazosin 1 mg 1 capsule once daily at bedtime
9:00 p.m. Missed dosage on , 13th and
14th, 2022
Is used alone or in combination with other
medications to treat high , . High
, is a common condition and when
not treated, can cause damage to the ,

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{A 025}	Continued From page 12 , , , , and other parts of the body. Damage to these may cause , a , , loss of vision, and other problems. 20 mg 1 tablet once daily 9:00 p.m. Missed dosage on , 13th, and 14th, 2022 Is used to lower levels of and triglycerides in the , it may reduce the risk of or in patients with risk factors for , and to decrease the chance that surgery will be needed in people who have or who are at risk of developing . , Fum 200 mg 1 tablet twice a day 9:00 a.m. and 5:00 p.m. Missed dosage on and 14th, 2022 Is used to treat the symptoms of , (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions, used alone or with other medications to treat episodes of (frenzied, abnormally excited, or irritated) or , in patients with , (; a that causes episodes of , , episodes of , and other abnormal moods. If you suddenly stop taking , , , you may experience withdrawal symptoms such as , , and difficulty falling asleep or staying asleep. 25 mg 1 tablet once a day 9:00 a.m. Missed dosage on and 14th, 2022. Is used to treat major , - , ( ), , , social , ( ), and post- stress ( )	{A 025}		

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{A 025}	Continued From page 13 Stopping . . . . . abruptly may result in one or more of the following withdrawal symptoms: irritability, ... , feeling . . . . , ... , nightmares, , and/or paresthesia's. On . . . . . at 10:40 a.m. Staff H stated "Resident #13 came yesterday at 9:30 a.m." On at 10:48 a.m. Interview with Resident #13, stated "I went to downtown, and I was at a friend's house. I visited a jewelry man and I saw his sister who was my girlfriend and I stayed with her for 3 days. I did not call the facility because I forgot my phone charger. I left after lunch and I took the medication for the night, I did not take my medications for the other days." Resident was observed with a on his right . , . , he stated that he went to the gym and a dumbbell over his . . On at 12:13 p.m. Interview with The Director of Nursing. She stated that "if a resident comes to the north station to sign out, then the staff asks the residents where they are going, but if the residents don't come to the north station, the staff don't ask them where they are going; we looked at the camera, and we saw him signing out." On . . . . . at 12:14 p.m. Record review of the facility's sign-out log showed Resident #13 singed out on . . . . . at 10:30 a.m. and came at 1:00 p.m., On the same day Resident #13 last sign out was at 5:00 p.m. Further review showed that the resident's destination was not recorded. There were no locations provided on both times on . It was shown as "Out". Also observed in the Resident sign-out Log for the date of , Resident #13 and	{A 025}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953671	A. BUILDING: _____ B. WING _____	R 01/26/2022

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

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{A 025}	Continued From page 14 Resident# 45 did not provide a location where they were going. It was shown as "Out". In addition, Resident #39, #45, and #143 for the date of did not provide a location where they were going. It was also shown as "Out". On at 1:45 p.m. Staff Z and Staff KK both agreed they would not know the Residents' whereabouts if the Resident did not document it on the facility's sign-out log. Staff KK also stated, "if the Residents are not by 9:00 p.m. we call the family members and if the resident is not there, then we call the police." Staff Z stated, "there is also a 2-hour CNA log for all Residents in the facility." On at 1:52 p.m. Interview with the Director of Nursing, she stated, "If the Resident goes out in the morning, they should be the latest, by lunch hour. The front desk should know where the Residents are going." On at 1:58 p.m. Facility record review of the 2-hour CNA log for Resident #13 revealed that on at 5:00 p.m., 7:00 p.m., and 11:00 p.m. it was shown as "Out". And no further detail description of Resident #13 whereabouts was noted. On the 2-hour CNA log revealed at 1:00 a.m., 3:00 a.m., 5:00 a.m., and 7:00 a.m. also shown as "Out" and no further detail description of Resident #13 whereabouts was noted. On at 12:18 p.m. The Administrator stated that Resident #13 returned to facility on Saturday . The Administrator further stated, "he signed himself out after meeting someone online. and he is oriented x3; when Resident #13 returned on , the staff	{A 025}		

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{A 025}	Continued From page 15	{A 025}		

asked him where he went. Resident #13 said he met a man online and he went out with him. It isn't considered an elopement if a resident signs out."

On at 12:20 p.m. Record review of Resident #13 showed a Police case# PD220113013451 dated , progress notes, and a signed refusal of treatment form. On It was documented that the medication technician called and stated resident #13 returned to the facility. "Upon assessment resident stated he got depressed, got a bus, went to downtown. Resident noted with around left and . Resident did not remember how he got it, denies , refused treatment."

On at 12:30 p.m. Observed Resident #13 had a hematoma ( ) around his left and a small hematoma to the left lower forehead. There was no redness to the left . Resident #13 denied blurred vision.

On at 12:51p.m. Interview with Resident #13, he stated "something happened, somebody punched me when I was in downtown, I don't need any medical attention."

at 4:00 p.m. Review of the facility's elopement policies and procedures revealed, "Elopement", is referred to as the occurrence in which a resident leaves the facility without following policy and procedure and the point which a resident's general whereabouts are unknown to the facility staff.
As per policy and procedures stated "Although the resident may travel independently in the community, the staff are responsible for knowing the general whereabouts of all residents. When the resident is determined missing or their

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{A 025}	Continued From page 16 whereabouts unknown, the facility shall make every attempt as quickly as possible to locate the resident." . . . . . at 4:11 p.m. Interview with Staff HH regarding the whereabouts of Resident #141, she stated "He is out at work, I don't know where". . . . . . at 4:11 p.m. Interview with the Director of nursing, regarding the whereabouts of Resident #141, "I heard he is working. I don't know where he works." On at 4:20 p.m. Interview with the Administrator regarding Resident #141, the Administrator stated "We don't know where he works. The previous administration gave him all kinds of privileges. He has his own car and has some job in Aventura. But his schedule is 7:00 a.m. to 11:00 p.m." Class I Based on observation, record review, and interview, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for one out of sixty-three residents. Resident # 13 eloped from the facility and returned 3 days later with a black . . . Findings Included: During an inspection on the morning of the Administrator stated that the facility had not reported the incident.	{A 025}		

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{A 025}	Continued From page 17 A review of Resident #13's health Assessment completed on showed Resident had medical history and diagnoses of Prostatic Hyperplasia, Hx (history) of Congenial Subglottic , Overactive , Hx of , of vocal Hx of . The resident was described as "NO" elopement risk; The resident was independent with all activities of daily living including ambulation, bathing, , eating, grooming, toileting, and transferring. The resident needed assistance with self-administration of medications. On Record review revealed Resident #13's health assessment had not been updated since his return to the facility on A review of Resident #1's medication observation records (MOR) showed Resident #13 missed the following medications on thru : According to the US National Library of Medicine: D3 1000 1 capsule once daily 9:00 a.m. Missed dosage on 13th, 14th, 2022 Is used as a dietary supplement in people who do not get enough D in their diets to maintain adequate health D2 50,000 IU, 1 capsule once a week, 9:00 a.m. Missed dosage on Is used to treat and prevent Therapeutic (Therems) tablet, 1 tab once daily, 9:00 a.m. Missed dosage on and 14th, 2022 Is used to treat deficiencies, lack of	{A 025}		

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{A 025}	Continued From page 18 . . may cause illness, poor nutrition, . . , and many other conditions. 12% Lotion, apply , , on skin Once daily 9:00 a.m. Missed dosage on . . and 14th, 2022 Is used to treat dry, scaly skin. Indicated to treat itching caused by dry skin. Ensure Enlive strawberry Drink one bottle by . . . as directed (twice daily) 9:00 a.m. and 5:00 p.m. Missed dosage on and 14th, 2022 Is used as a nutritional supplement. 500 mg, take 1 tablet by twice a day, 9:00 a.m. and 5:00 p.m. Missed dosage on and 14th, 2022 Is used together with diet and exercise to improve . control in adults with type 2 . . . . 20 mg, 1 tablet twice a day, 7:00 a.m. and 4:00 p.m. Missed dosage on and 14th, 2022 Is used to treat and prevent in the . and . . . . , . . . tart 25 mg 1 tablet twice a day, 9:00 a.m. and 5:00 p.m. Missed dosage on and 14th, 2022 Is used to treat , and high . . . . . It is also used to lower your risk of or needing to be hospitalized for . . . . If not taken as prescribed, it could raise your chances of a a , , . . . , or other complications. . . . . . 2 % Cream (30G 2% cream) Apply , , to nails twice daily, 9:00	{A 025}		

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{A 025}	Continued From page 19 a.m. and 5:00 p.m. Missed dosage on and 14th, 2022 It is used to treat certain caused by Prazosin 1 mg 1 capsule once daily at bedtime 9:00 p.m. Missed dosage on , 13th and 14th, 2022 Is used alone or in combination with other medications to treat high . High is a common condition and when not treated, can cause damage to the , , and other parts of the body. Damage to these may cause , a , , , loss of vision, and other problems. 20 mg 1 tablet once daily 9:00 p.m. Missed dosage on , 13th, and 14th, 2022 Is used to lower levels of and triglycerides in the , it may reduce the risk of or in patients with risk factors for , and to decrease the chance that surgery will be needed in people who have or who are at risk of developing . , Fum 200 mg 1 tablet twice a day 9:00 a.m. and 5:00 p.m. Missed dosage on and 14th, 2022 Is used to treat the symptoms of , (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions, used alone or with other medications to treat episodes of (frenzied, abnormally excited, or irritated) or in patients with , (; a that causes episodes of , , episodes of	{A 025}		

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{A 025}	Continued From page 20	{A 025}		

, and other abnormal moods. If you suddenly stop taking , , you may experience withdrawal symptoms such as , , and difficulty falling asleep or staying asleep.

25 mg 1 tablet once a day 9:00 a.m. Missed dosage on and 14th, 2022. Is used to treat major , , ( ), , , social , ( ), and post- stress ( ) Stopping abruptly may result in one or more of the following withdrawal symptoms: irritability, , feeling , , nightmares, , and/or paresthesia's.

On at 10:40 a.m. Staff H stated "Resident #13 came yesterday at 9:30 a.m."

On at 10:48 a.m. Interview with Resident #13, stated "I went to downtown, and I was at a friend's house. I visited a jewelry man and I saw his sister who was my girlfriend and I stayed with her for 3 days. I did not call the facility because I forgot my phone charger. I left after lunch and I took the medication for the night, I did not take my medications for the other days." Resident was observed with a on his right , , he stated that he went to the gym and a dumbbell over his .

On at 12:13 p.m. Interview with The Director of Nursing. She stated that "if a resident comes to the north station to sign out, then the staff asks the residents where they are going, but if the residents don't come to the north station, the staff don't ask them where they are going; we looked at the camera, and we saw him signing

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{A 025}	Continued From page 21 out." On . . . . . at 12:14 p.m. Record review of the facility's sign-out log showed Resident #13 singed out on . . . . . at 10:30 a.m. and came at 1:00 p.m., On the same day Resident #13 last sign out was at 5:00 p.m. Further review showed that the resident's destination was not recorded. There were no locations provided on both times on . It was shown as "Out". Also observed in the Resident sign-out Log for the date of , Resident #13 and Resident# 45 did not provide a location where they were going. It was shown as "Out". In addition, Resident #39, #45, and #143 for the date of did not provide a location where they were going. It was also shown as "Out". On at 1:45 p.m. Staff Z and Staff KK both agreed they would not know the Residents' whereabouts if the Resident did not document it on the facility's sign-out log. Staff KK also stated, "if the Residents are not by 9:00 p.m. we call the family members and if the resident is not there, then we call the police." Staff Z stated, "there is also a 2-hour CNA log for all Residents in the facility." On at 1:52 p.m. Interview with the Director of Nursing, she stated, "If the Resident goes out in the morning, they should be the latest, by lunch hour. The front desk should know where the Residents are going." On at 1:58 p.m. Facility record review of the 2-hour CNA log for Resident #13 revealed that on at 5:00 p.m., 7:00 p.m., and 11:00 p.m. it was shown as "Out". And no further detail description of Resident #13 whereabouts	{A 025}		

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{A 025}	Continued From page 22	{A 025}		

was noted. On [redacted] the 2-hour CNA log revealed at 1:00 a.m., 3:00 a.m., 5:00 a.m., and 7:00 a.m. also shown as "Out" and no further detail description of Resident #13 whereabouts was noted.

On [redacted] at 12:18 p.m. The Administrator stated that Resident #13 returned to facility on Saturday [redacted]. The Administrator further stated, "he signed himself out after meeting someone online. and he is oriented x3; when Resident #13 returned on [redacted], the staff asked him where he went. Resident #13 said he met a man online and he went out with him. It isn't considered an elopement if a resident signs out."

On [redacted] at 12:20 p.m. Record review of Resident #13 showed a Police case# PD220113013451 dated [redacted], progress notes, and a signed refusal of treatment form. On [redacted] It was documented that the medication technician called and stated resident #13 returned to the facility. "Upon assessment resident stated he got depressed, got a bus, went to downtown. Resident noted with [redacted] around left [redacted] and [redacted]. Resident did not remember how he got it, denies [redacted], refused treatment."

On [redacted] at 12:30 p.m. Observed Resident #13 had a hematoma ([redacted]) around his left [redacted] and a small hematoma to the left lower forehead. There was no redness to the left [redacted] Resident #13 denied blurred vision.

On [redacted] at 12:51p.m. Interview with Resident #13, he stated "something happened, somebody punched me when I was in downtown, I don't need any medical attention."

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{A 025}	Continued From page 23 . . . . . at 4:00 p.m. Review of the facility's elopement policies and procedures revealed, "Elopement", is referred to as the occurrence in which a resident leaves the facility without following policy and procedure and the point which a resident's general whereabouts are unknown to the facility staff. As per policy and procedures stated "Although the resident may travel independently in the community, the staff are responsible for knowing the general whereabouts of all residents. When the resident is determined missing or their whereabouts unknown, the facility shall make every attempt as quickly as possible to locate the resident." . . . . . at 4:11 p.m. Interview with Staff HH regarding the whereabouts of Resident #141, she stated "He is out at work, I don't know where". . . . . . at 4:11 p.m. Interview with the Director of nursing, regarding the whereabouts of Resident #141, "I heard he is working. I don't know where he works." On at 4:20 p.m. Interview with the Administrator regarding Resident #141, the Administrator stated "We don't know where he works. The previous administration gave him all kinds of privileges. He has his own car and has some job in Aventura. But his schedule is 7:00 a.m. to 11:00 p.m." Class II	{A 025}		
{A 030} SS=L	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007	{A 030}		

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{A 030}	Continued From page 24 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [illegible] 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- [illegible] 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;	{A 030}		

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{A 030}	Continued From page 25 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical 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	{A 030}		

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guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the 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

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{A 030}	Continued From page 27 regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and 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	{A 030}		

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{A 030}	Continued From page 28 jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without . . . . . , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, ... , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, ... Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are 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	{A 030}		

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{A 030}	Continued From page 29 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 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 interview, the facility failed to ensure that 142 of 142 sampled residents lived in a safe and decent environment (All Residents, #1 through 142). The facility had 161 calls for emergency service in less than a year, including the [illegible] of Resident #36 onsite. After an unreported change in the use of licensed bed space to accommodate a population of 52 residents who were not under the supervision of staff, no measures were taken to ensure the safety of more people who needed assistance or supervision with activities of daily living. The facility also failed to provide all facility residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication. The facility failed to provide the forty-five	{A 030}		

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days-notice for relocation for three out of 142 (Resident #61, #22 and #14) sampled residents.

Findings included:

1)
On [redacted] at 8:20 AM the Administrator stated that Resident #36, had been "decapitated" by his lover. She further stated that there also been a lot of drug and [redacted] use, assaults, and other crimes at the facility, most occurring in 'Building B'. She stated the Owner told her building B was not licensed and was independent living. She stated building B had been rented out in collaboration with a company that housed homeless persons.

A review of autopsy reports showed that Resident #36 was [redacted] at 3:00 am in unit B 310 by his domestic partner on [redacted]. According to the fire rescue and autopsy reports, "on [redacted], Miami-Dade Police officers responded to the residence located at 280 Sierra Drive, Apt # B-310, Miami, Florida 33179 in reference to a report of a violent verbal dispute. The decedent was involved in an argument with his live-in boyfriend. The argument then became physical and the decedent was stabbed multiple times. Upon police arrival to the apartment, the decedent was discovered unresponsive in his bedroom lying in a pool of [redacted] with a knife near his body. Emergency medical services were summoned. Fire Rescue was dispatched and responded to the scene under incident and pronounced her (sic) on the scene. According to the rescue report, he was found lying prone on the bedroom floor. The decedent's [redacted] and [redacted] were absent. He had a [redacted] across his [redacted]. He was also [redacted] with signs of rigor to his upper extremities. He was

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pronounced upon arrival by fire rescue personnel at 6:49 AM."

Regarding the evidence of injury, the medical examiner's report stated, "This stab penetrates through skin, fat, and of the -lateral aspect of the left side of the and enters the canal between the third and fourth transecting the cord. Associated with this stab is , and cord . The stab extends to an approximate depth of 8 cm. The knife blade is 10 x 2 cm in dimension."

A review of the incident report database revealed that Resident # 36's had not been reported. Further review of facility records showed that it did not report the occupancy of building B by independent living residents.

A review of calls to service records from Emergency Services (Police/Fire/Medical) revealed that there were 161 calls to service at the facility's address between and , including 7 burglaries, 4 larcenies, 10 assaults, 46 disturbances, 3 missing persons, 5 persons on arrival (including Resident # 36), and 3 investigations.

On from 6:40 AM to 2:45 PM observation revealed 63 residents receiving care and services onsite with three more hospitalized. Additionally, 52 residents were observed living in building B, which the Administrator stated the Owner had told her was independent living and not a part of the assisted living facility. Further observation revealed there were no gates installed to avoid the residents from building B passing into building C; state representatives were able to pass from building C into building B

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{A 030}	Continued From page 32 from the 2nd, 3rd, 4th and 5th floors. (Photographic evidence obtained.) A review of facility and agency records showed that the facility kept no documentation onsite regarding residents living in Building B, although it was licensed as an assisted living facility by the state. On at 8:20 AM the Administrator stated that Resident #37 was living in building C because she refused to move out of her unit. The Administrator stated that there were no barriers or locks preventing residents from building B from coming to building C and Resident # 37 without staff knowledge. She stated that she had increased staff's supervision of Resident # 37 to try to protect her. Review of Resident #37's health assessment showed that she was diagnosed with , , and unspecified . On observation revealed an approximately distance of 500 from Resident # 37's room in building C to building B and there were no barriers to prevent residents from building B to pass into building C.(photographic evidence obtained.) On at 1:50 PM Resident # 38, who lived in building B stated, "When I came to live here, there was nobody. The police came because they killed someone in 310, that guy used to work here before cutting the grass. There are thousands of problems here. The guy got stabbed like 5 times. There is a lot of drug use here. Time ago I left my door opened and someone entered and stole my purse with $370. I forgot to lock the door. I think he was stabbed like 32 times. The guy that	{A 030}		

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{A 030}	Continued From page 33 stabbed him used to live before on the fifth floor with his mother, who got evicted. There was a restriction order against him, but Resident # 36, he brought the guy to live with him. They said there were drugs in the apartment. I never go downstairs because there are a lot of drunks and people using drugs. ." On . . . . . at 2:41 PM, Maintenance Director stated regarding the in unit B310 and the ability of residents from Building B to access the rest of the facility, "In the morning a resident called me and told me that there was a fight and I told him to call the police. I got here at 7 AM and the police had the guy in the police car. The police said that we could not enter the apartment. I do not know what the company has done. They have not told us what to do. We keep the gate closed but they come in and out and do not close the gate, they cover the censor. They use the elevator in building A and also the one on building C. I have seen people, but I do not know the ones that live there." On . . . . . at 3:05 PM Staff HH, a previous administrator who worked at the facility from the beginning of through , stated regarding building B and the lack of actions to prevent reoccurrence after the in unit B310, "To my knowledge those units over there were independent, I was told that area was an independent living and that only C and D were the assisted living facility. They were going to install gates that were on the premises. No training after it happened." On . . . . . at 2:41 PM the Maintenance Director, stated that the independent living residents go into the building trough Building A, using the elevator or the stairs. He could not	{A 030}		

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{A 030}	Continued From page 34 really identify who were residents and who were visitors because he might know a few people but not all the persons living there. There were stairs in building C & B and at the front desk in building D was always someone. For going out they used parking lot in building B or stairs or elevator in building C. On . . .. at 9:04 AM Resident # 46 stated that in the beginning of his stay, the facility was sweet, and when the facility switched [a change of personnel] it became bad. Further stated, "I don't feel safe, and they called the police on me." Stated that he became upset a couple of weeks ago when he came to breakfast and it took the dining staff one hour for breakfast, the kitchen is a mess, and you cannot get any carry-out or wares. In terms of the , he stated did not know anything about it because he kept to himself and trusted no one. On at 9:09 AM Resident # 59 stated, "I know they use to sell marijuana here; I don't know who, but I know they did. There was a in the independent building about months ago. This place is falling apart. A lot of stuff going on around here. The administrator is a nightmare, she told me if I don't go to my doctor's . , , ... , I will go to jail. She is trying to get rid of everyone here. She sends people to the hospitals for no reason, so they won't be able to come to the facility. I am looking for another place to move with my girlfriend." On . . . . at 9:13 AM Resident # 144 stated, "This place was ok before this new people came, everyone that used to work here left because this place is falling apart, and it is a nightmare." On at 9:16 AM Resident # 66 stated. "I	{A 030}		

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know about a . . . . that happened in the other building. I personally don't like it here anymore. It is getting worse by the day. This place was not bad before, sometimes they don't even have juice or butter for the bread, they say they ran out."

On . at 9:27 AM Staff DD, activities director, stated that she did not feel safe at the facility and found out about the . . . through a co-worker. Staff DD further stated that the facility declined, and there was no security. She stated, "the independent living residents go upstairs and walk through the corridor and have access to the assisted living facility residents."

On at 10:25 AM independent living Resident # 42, stated, "I found out about the . . . . guy when I saw the police. The guy that was . . . . . was the yard guy, the security. They were using drugs a lot. There was a lot going on that apartment. There is (sic) people getting drugged, bringing prostitutes. Too much happening here, that I am scared; people getting high, fights. Somebody on the fifth floor, and I don't know if he . and broke his . . . . A lady called the police because a guy kept coming to her apartment and they ' . . . . . ' (sic) him."

On . . . . . At 8:15 AM the Security Staff, stated that he works the weekends from 7 AM to 7 PM. He stated, "I live in the independent living in building A. I have lived here for a year and 3 months. They need to do something with the people there. At night there is noise and fights. The one that got killed, he and his lover used drugs and was very jealous and stabbed him 32 times. There are people with . . . . . and drug and that is the problem I see."

On at 10:44 AM Staff N, from

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maintenance, stated that he worked in the building from 7 AM to 3 PM from Monday to Friday and from 7 AM to 11 AM on Saturdays. He arrives at 7:00 AM every day. He stated he opened the model apartment and the gym when arrived every day. He stated he smelled a strong odor of marijuana in the parking lot and the halls sometimes. He said he found a lot of cans of beers.

On at 9:43 AM the Security Company Owner stated, "I have a contract with Grand Court Lakes since 2014 and only provide service for the overnight shift from 11:00 PM-7:00 AM. The security is only on the front desk and looking at the cameras. I was not informed of any and have not make any changes to the security. There are gates to get into the parking lot and on the first floor to go to the other buildings the gate has a code. Also, on the other floors there are gates with code. I go there every Monday to pay the security guard, but I do not go inside."

On at 9:45 AM, observation revealed no gates between buildings on the 2nd, 3rd, 4th and 5th floors.

A review of the residents' records revealed that several residents living at the facility were suffering from or other issues that added to their vulnerability as possible victims of violence:

-Resident # 27, Health Assessment completed on showed medical history and diagnosis of ( ), Right ( ), Major Gait Disturbance,

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{A 030}	Continued From page 37 , Arthralgia right . Required assistance with Ambulation, Bathing, , Toileting, and Transferring, supervision with Self-care (grooming) and needed assistance with self-administration of medication. - Resident # 43, Health assessment completed on showed medical history and diagnosis of Right sided ( ) with residual left side , Type II with , (history of), Tobacco dependence Required assistance with, ambulation, bathing, , self-care (grooming), transferring, and Toileting. Needed Assistance with self-administration of medication. -Resident # 44, Health assessment completed on showed medical history and diagnosis of Diagnoses: . Required assistance with ambulation, bathing, , self-care (grooming), and transferring, and Toileting, and supervision with eating. -Resident # 6, Health assessment completed on showed medical history and diagnosis of Post COVID-19, , . Required assistance with ambulation, bathing, , eating, self-care (grooming), transferring, and Toileting. Needed Assistance with self-administration of medication. - Resident # 46, Health assessment completed on showed medical history and diagnosis of with Left Sided	{A 030}		

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{A 030}	Continued From page 38 Affecting Left Side, Spasms. Required supervision with transferring and required assistance with ambulation, bathing, and toileting. Used wheelchair. Needed Assistance with self-administration of medication. -Resident # 47, Health assessment completed on showed medical history and diagnosis of , Hard of Hearing, , , Abnormal . Required supervision with toileting and assistance with bathing and . Needed Assistance with self-administration of medication. -Resident # 48, Health assessment completed on showed medical history and diagnosis of Unspecified Sequelae of . The resident was alert with moderate on decision making. Requires assistance with all activities of daily living. Needed Assistance with self-administration of medication. -Resident # 9, Health assessment completed on showed medical history and diagnosis of , Lymphedema, , Major , Uses . Required assistance with ambulation (walker), bathing, , toileting and transferring. - Resident # 49, Health Assessment dated showed medical history and diagnosis of , Unspecified, . The resident used a	{A 030}		

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{A 030}	Continued From page 39 wheelchair. Required supervision for ambulation, bathing, , eating, self-care, toileting, and transferring. Resident needed assistance with self-administration of medication. -Resident # 50, Health Assessment completed on showed medical history and diagnosis of , , history of above of right lowered extremity, Tightness, Supplemental Dependent. The resident was admitted to hospice services. Required assistance with ambulation, bathing, and supervision with transferring. Resident needs assistance with self-administration of medication. -Resident # 51, Health Assessment dated showed medical history and diagnosis of Artero- ( ). Status post left repair and right repair. Decline in function. , on . Required Supervision in Ambulation, eating, self-care, transferring, and Assistance in bathing, , and toileting. Resident needs assistance with self-administration of medication. -Resident # 52, Health Assessment completed on showed medical history and diagnoses of , , status post left . Required assistance in all activities of daily living (ambulation, bathing, , eating, self-care (grooming), toileting and transferring; and needed assistance with the self-administration of medication. - Resident # 53, Health Assessment completed	{A 030}		

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{A 030}	Continued From page 40 on [redacted] showed medical history and diagnoses of [redacted] of [redacted] generalized [redacted]. Required assistance in ambulation, bathing, [redacted], self-care (grooming), toileting and transferring; and needed assistance with the self-administration of medication. -Resident # 64, Health Assessment completed on [redacted] showed medical history and diagnoses of [redacted], Atherosclerotic [redacted], Paranoia, [redacted], restlessness and agitation, [redacted], and [redacted]. Required supervision with transferring and assistance with ambulation, bathing, [redacted], grooming and toileting. -Resident # 54, Health Assessment completed on [redacted] showed medical history and diagnoses of [redacted] both [redacted], Paresthesia, [redacted], Abnormalities of [redacted] and mobility, unspecific [redacted], Atherosclerotic, [redacted] of native [redacted], without [redacted] pectoris, Major [redacted]. Required supervision with [redacted] and transferring and needed assistance with ambulation and bathing. Needed Assistance with self-administration of medication. -Resident # 58, Health Assessment completed on [redacted] showed medical history and diagnoses of [redacted] Atherosclerotic [redacted], in right [redacted]	{A 030}		

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{A 030}	Continued From page 41 , and . Required supervision with the ambulation, eating, grooming, bathing, toileting and . Needed Assistance with self-administration of medication. -Resident # 57, Health Assessment completed on showed medical history and diagnoses of Intoxication (ETOH). Required assistance with ambulation. Needed Assistance with self-administration of medication. -Resident # 56, Health Assessment completed on showed medical history and diagnoses of , and . Required supervision with ambulation, , grooming and toileting and needed assistance with bathing. Needed Assistance with self-administration of medication. - Resident # 45, Health Assessment completed on showed medical history and diagnoses of , Status Post COVID-19, , mobility issues, , Unsteady gait. Required assistance with ambulation. Needed Assistance with self-administration of medication. - Resident # 55, Health Assessment completed on showed medical history and diagnoses of 2, Major , visual	{A 030}		

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{A 030}	Continued From page 42	{A 030}		

carotid
Required supervision with bathing, and grooming. Needed Assistance with self-administration of medication.

- Resident # 21, Health Assessment completed on showed medical history and diagnoses of 's , and
Required supervision with bathing, and toileting. Needed Assistance with self-administration of medication.

-Resident # 66, Health assessment completed on showed medical history and diagnoses of , History of , History of , History of
Mobility, D Deficiency, Low . Used wheelchair. Required with ambulation, bathing, and toileting. Needed Assistance with self-administration of medication.

- Resident # 67, Health assessment completed on showed medical history and diagnoses of , Ataxia, Lower . Used wheelchair. Required assistance with ambulation. Needed Assistance with self-administration of medication.

-Resident # 69 health assessment completed on showed medical history and diagnosis of Type II , Other , Acute , Absolute , other , , Absence left upper , right

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{A 030}	Continued From page 43	{A 030}		

below-the- and, . Required assistance with activities of daily living including bathing and . Needed Assistance with self-administration of medication.

-Resident # 39 health assessment completed on showed medical history and diagnosis of . Required supervision with Ambulation. Needed assistance with self-administration of Medication.

-Resident # 5 health assessment completed on showed medical history and diagnosis of , Adjustment . Required supervision with transferring, toileting, bathing, , eating and grooming. Needed assistance with Self-Administration of medication.

-Resident # 72 health assessment completed on showed medical history and diagnoses of , history of falling, , restlessness, Agitation. Required assistance with bathing and Self-care (Grooming). Needed Assistance with self-administration of medication.

2-
On observation revealed that there was a phone installed on each floor in a common area, for use by resident who did not have their own telephone service. Further observation revealed that the phones had no dial tone and were not functional.

On at 10:09 AM the Administrator stated, "The owners took out the phones because

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{A 030}	Continued From page 44 they did not want to pay for it." Uncorrected Class I	{A 030}		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a	A 093		

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A 093	Continued From page 45 licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal	A 093		

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A 093	Continued From page 46 to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of [illegible] the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on [illegible]. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on [illegible] at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to post a current menu, and provide snacks for residents. The facility failed to ensure that no more than 14 hours elapsed between the end of an evening meal	A 093		

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A 093	Continued From page 47 containing a protein food and the beginning of a morning meal. Findings included: Observation on at 8:01 AM found expired lunch menus posted for the weeks of - and - and no breakfast menu. In addition to the expired menu, interviewed Residents on , found more than a 14-hour lapse between the end of an evening meal. The facility Snack Scheduled posted showed 3:00 PM and 7:00 PM snacks times. Interviewed on at 6:57 AM, Resident #21 stated that she was hungry, and that the facility does not provide them snacks after dinner. Resident #21 further stated, "the last time I ate was at 4:00 PM yesterday." Interviewed on at 7:02 AM, Resident #52 stated, "we never receive snacks." Interviewed on at 7:19 AM, Resident #27 stated, "we receive snacks sometimes and the food is terrible." Interviewed on at 7:25 AM, Resident #73 stated, "snacks are served every couple of days, and we are fed peanut butter and jelly and water." A review Resident #21's Health Assessment dated showed a medical history of and diagnosis of , , , , Deficiency, , , D deficiency, 's , and . The resident is	A 093		

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A 093	Continued From page 48 independent in ambulation, eating, self-care, transferring, but needs supervision with bathing, [illegible] and toileting. The resident is not an elopement risk but has special dietary instructions of no added salt. A review of Resident #52's Health Assessment dated [illegible] showed a medical history and diagnosis of [illegible] S/P B/L [illegible]. The resident needed assistance with ambulation, bathing, [illegible], eating, self-care, toileting, and transferring. The resident is not an elopement risk but has special dietary instructions of no added salt. A review of Resident #27's Health Assessment dated [illegible] showed a medical history and diagnosis of [illegible], Right [illegible] Major [illegible], [illegible]. Trinities, [illegible], Gait Disturbance, [illegible] Right [illegible]. The resident needed assistance with ambulation, bathing, [illegible], toileting and transferring but independent in eating. The resident is not an elopement risk and has special Dietary instructions of no added salt. A review of Resident #73's Health Assessment dated [illegible] showed a medical history and diagnosis of an Unstable Gait, [illegible], Acute [illegible] Injury History, [illegible] Disturbance, [illegible]. The resident is independent in ambulation, bathing, [illegible], self-care, toileting, eating and transferring. The resident is not an elopement risk but has special dietary instructions of no added salt.	A 093		

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A 093	Continued From page 49 Interviewed on at 8:01 AM, the Kitchen Manager stated, "it is my fault. I have been on vacation. Let me print breakfast for you. We feed snacks at 3:00 PM and 7:00 PM, just look at the schedule." Class III	A 093		
{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 or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate	{A 152}		

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{A 152}	Continued From page 50	{A 152}		

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, interview and record review, the facility failed to maintain a safe and living environment.

Findings include:

1)
Observation on at 6:57 AM, found a refrigerator door located in D-215 (Memory Care Floor Kitchen Area) was covered with visible rust.

Observation on at 1:25 PM found Resident #142 smoking in his Room D-203.

Interviewed on at 1:25 PM, the ADON (Assistant Director of Nursing) stated, "We tell them all the time about smoking in the rooms."

Interviewed on on at 3:51 PM regarding Resident #142, The Administrator stated, "we have told him about smoking in the room."

2)
Reviewed of the Smoking Policy found:
"Residents should be informed before admission that smoking is allowed only in designated

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{A 152}	Continued From page 51 area(s) outside the building. If residents smoke in any other areas the behavior should be addressed in a timely manner to ensure that it does not occur." Observation on at 1:28 PM found a cat unsupervised in Room D-201 belonging to Resident #141. Facility and resident record review revealed no documentation of a license or shot records for the cat. Interviewed on on at 3:50 PM regarding Resident #141, the Administrator stated regarding the cat and Resident #141, "He has no papers on the cat. We served him a 45-day notice for the cat because he won't get rid of the cat." 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.	A 160		

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A 160	Continued From page 52 (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 [illegible]; 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 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 [illegible]. (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 [illegible]'s [illegible] or related [illegible], a copy of all such facility advertisements as required by section 429.177, F.S.	A 160		

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A 160	Continued From page 53 (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, 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/discharge log.	A 160		

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	AL11953671	A. BUILDING: _____ B. WING _____	R 01/26/2022

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A 160	Continued From page 54 Findings included: Review of the facility's census showed that Residents #4, #10, #14, #15, #22, #30 and #140 were not listed. A review of the facility's admission/discharge log revealed that Residents #4, #10, #14, #15, #22, #30 and #140 had no discharge date. On at 4:10 PM, the Administrator stated that the person in charge of the admission/discharge log no longer worked at the facility and did not complete the log. Class III	A 160		
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment	{A 162}		

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{A 162}	Continued From page 55	{A 162}		

form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.
(c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.
(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.
(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.
(f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually.
(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging

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{A 162}	Continued From page 56 to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C.,	{A 162}		

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{A 162}	Continued From page 57 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided 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: Uncorrected Based on record review and interview, the facility failed to have an accurate and updated health assessment after a significant change for 4 out of 140 sampled residents (Residents #29, #43, #66, #67). Also, the facility failed to have a completed health assessment for 1 out of 140 sampled residents (Resident #73). 1) A review of the facility's monthly incident/accident report showed that: Resident #29 in the bedroom on , Resident #43 from the bed on , Resident #66 in the bathroom on	{A 162}		

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{A 162}	Continued From page 58 and Resident #67 in the bedroom on . A review of Resident #29's health assessment completed on showed medical history and diagnoses of , , , use (ETOH), , gait mobility difficulty, , . The health assessment showed that the resident had risk special precautions. The resident needed supervision with bathing and toileting; and needed assistance with and self-administration of medication. A review of Resident #43's health assessment completed on showed medical history and diagnoses of right sided ( ) with residual left side 2 (DM2) with , , ( ), , , (history of), tobacco dependence , ( ), , of , . Resident #43 needed assistance with ambulation, bathing, , self-care (grooming), transferring and toileting. A review of Resident #66's health assessment completed on showed medical history and diagnoses of , , history of , history of , history of , toothache, , mobility, D deficiency, , low . Resident #66 required supervision with ambulation, bathing, and toileting. The resident used a wheelchair and was on precautions.	{A 162}		

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{A 162}	Continued From page 59	{A 162}		

A review of Resident #67's health assessment completed on showed medical history and diagnoses of , , ataxia, lower , , . Resident #67 required assistance with ambulation and the use of wheelchair.

None of the residents were re-assessed after the .

2) A review of Resident #73's health assessment completed on showed medical history and diagnoses of unstable gait, , acute , injury history, , , , ( ), , disturbance, , . Further review showed that the nursing/treatment/ , service requirements section was left blank.

On at 2:42 PM, the Administrator acknowledged that the residents were not re-assessed.

Uncorrected
Class III

A 182 SS=I	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation	A 182		

(3) PLAN IMPLEMENTATION.
(a) All staff must be trained in their duties and are responsible for implementing the emergency management plan.
(b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining

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A 182	Continued From page 60 communication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all staff were trained in their duties and would be responsible for implementing the emergency management plan. Staff BB was unaware of how many residents were living in the facility. In case on an emergency and would not be able to provide the exact number of residents living there if evacuation was required. Findings Included: On at 6:42 AM, Staff BB stated he has been working in the facility for two and a half years thru a Security Agency and that he was unsure of the physical residents count. He stated, "68 residents, I think." On at 7:02 AM, Staff O stated that there was no one living in Room# D-207. Observation revealed that Resident #52 was found in Room# D-207 with a walker, coming out of the restroom. On at 8:15 AM observation revealed that the Administrator provided a census indicating occupancy by 65 residents. Interviewed on at approximately 10:00 AM, the Maintenance Director stated, regarding Building B, that he did not have access to the 51 units in the building, and that he did not have a master key. He further stated that the ground floor of Building B contained only vacant units. Observation revealed that the Maintenance Director asked the Maintenance Man to open the units. On at 11:18 AM, when asked to provide	A 182		

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A 182	Continued From page 61 access to the units, the Administrator stated that she did not have access, and that the Owner would not provide access or contracts for Building B. At approximately 11:40, the Owner's representative was informed that the facility was required to provide access to the licensed units. A short while later during a second tour of Building B, when asked to provide access to the units on the first floor, the Maintenance Director restated that all the units on that floor were empty. After a tour was completed of floors two through five, where each unit except B310 was occupied, the Maintenance Director was asked to open the units on the first floor which he stated were empty. Observation revealed that units B108, B107, B106, B105, B104, and B103, each had one resident living within. On [redacted] at 11:50 AM observation revealed that Resident #74 was found in Room #D407, and Resident #75 in Room #D 408. A review of the facility's census revealed that these two residents were not listed. Staff FF stated, just prior to the resident being observed, that there was no one living in that unit. On [redacted] at 12:30 PM observation revealed that Staff Y provided another resident census which identified 66 residents living in the facility. On [redacted] at 12:30 PM observation revealed that the facility had 63 residents receiving care and services onsite with three more hospitalized. In addition, 52 residents were living on site in units that Staff M had said were empty. These residents were occupying apartments licensed as Assisted Living Facility units. Class II	A 182		