

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A Full Survey was conducted at Courtyard Plaza on 12/15/2022 in conjunction with a revisit inspection. Deficiencies were identified at the time of survey.	A 000		
A 030 SS=E	59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.	A 030		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 1 (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. _____ and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident _____, neglect, and _____; 6. Administrative and housekeeping schedules and requirements; 7. _____ control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical _____. (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.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 2 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the 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.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 3 (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 4 telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (1) 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA		STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated incompetent or incompetent 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 interview, observation, and record review the facility failed to treat with consideration and respect for the need for privacy to two of the 108 sampled residents (Resident #1 and #11). Findings included: On _____, at 7:45 am, Resident #1 stated that since _____ of 2022, the housekeeper consistently invaded his privacy early in the mornings when he was in the bathroom. The	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

15520 NW 2 AVENUE

NORTH MIAMI BEACH, FL 33160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 6 resident stated that he already had spoken with the housekeeper to make her stop coming early in the mornings because he needed time to dress up due to his physical . A review of the resident record found no documentation the report or the interaction listed.. On , at 11:45 am, Resident #11 stated she was concerned about her personal items. She mentioned that the housekeeper went inside her room and opened the drawer to take her personal documents to put them inside the closet. Reviewed the Resident Grievance Report and found that Resident # 40 on said that around 7:30 am she walked into her room to find a staff member using her bathroom. Resident came to the administrator at 12:00 pm to let them know about this situation. The record stated that the Administrator and Resident Care Coordinator called the staff member to ask about the occurrence, and the staff member admitted that she needed to use the bathroom urgently as she "couldn't hold it". Facility record review revealed that on in the evening, Resident # 5 went to speak to Staff E (Resident Care Coordinator) about the incident. Resident # 5 said that the staff did not ask permission to use the microwave. The staff then responded that she did ask her for permission to use the microwave and the resident was "lying". Resident # 5 stated that the staff did not ask, she only walked into the room and used the microwave. Staff and resident record review revealed no documentation that the resident concerns about privacy were adequately addressed.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7	A 030		
A 078 SS=D	Class III 59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF: (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience.	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 078	Continued From page 8 Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on Record Review and Interview, the facility failed to ensure that two (B and C) out of the 14 sampled staff were qualified to perform their duties. Staff B and Staff C failed to demonstrate the appropriate technique for . Findings:	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 078	Continued From page 9 A record reviewed of Staff B and C's (caregivers) personnel files found current Adult First Aid/ Certifications cards. Interviewed on _____ at 1:56PM when asked about _____ and what he would if he found a resident unresponsive without _____ and not breathing, Staff B stated that he would perform _____ on the bed. Staff B stated further, "I would open up the airway and gave the resident 15-30 _____ and 60 breaths. This question was a surprise (referring to _____). I took the training about two months ago." Interviewed on _____ at 2:22 PM when asked about performing _____ on a _____ resident, Staff C said that he would perform _____ on a choking resident. Staff C stated further, "I would perform the _____ thrust. How can I put this? I would call 911. I think it all depends on what the 911 operator tells me what to do. We follow their orders. I took _____ this year online and in person. But we would be on call with 911 and they would tell us everything." A review of data from the American Red Cross showed that during _____, give sets of 30 _____ and 2 breaths. Use an _____ (Automated External Defibrillator) as soon as one is available." Interviewed on _____ at 3:19 PM the Administrator acknowledged the problem. The Administrator stated further, "We had training (_____) recently." Class III	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 123 A 123 SS=F	Continued From page 10 429.27() FS; 59A-36.013(2) FAC Fiscal - Resident Trust Funds 429.27 (3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of \$500 and funds of the resident not in excess of \$500 cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of \$500. (4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by a facility shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. At least once every 3 months, unless upon order of a court of competent jurisdiction, the facility shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the facility shall furnish such statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident. (5) Any personal funds available to facility residents may be used by residents as they	A 123 A 123			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 123	Continued From page 11 choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. A facility may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies. 59A-36.013 (2) RESIDENT TRUST FUNDS. Funds or other property received by the facility belonging to or due a resident, including personal funds, must be held as trust funds and expended only for the resident's account. Resident funds or property may be held in one bank account if a separate written accounting for each resident is maintained. A separate bank account is required for facility funds; co-mingling resident funds with facility funds is prohibited. Written accounting procedures for resident trust funds must include income and expense records of the trust fund, including the source and disposition of the funds. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to keep separate any funds belonging to, due to, or expendable from the residents'	A 123			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 123	Continued From page 12 accounts of 18 of 108 sampled residents (Residents # 3,4,22,25,32,34,46,39,40, 41,42,43,44,45,46,47,48,49). The facility failed to keep an accounting of funds residents had received as a part of a COVID-19 stimulus payment. The facility failed to provide, at least once every three months, quarterly statements to residents or their representatives, a complete and verified statement of all funds received, the sources, and disposition. Findings: A review of facility records revealed that the facility received COVID-19 stimulus payments for Residents # 3,4,22,25,32,34,46,39,40, 41,42,43,44,45,46,47,48,49. Further review revealed that each resident received \$1200, resulting in a total of \$21,600 that the facility received. Interviewed on _____ the Assistant Administrator stated that the other residents had not received a stimulus payment as far as she knew. She further stated that when the \$1200 was deposited into the facility's regular operating account because there should not be more than \$300 for a resident in the trust account. She said that when the trust account balance became low, she transferred from the operating to the trust account on the residents' behalf. On _____ at 2:50 pm, the Assistant Administrator stated that residents did not get a receipt, or a breakdown of how much they had spent, or how much they had left, for their regular funds. She further stated that they gave residents a verbal report of funds spent. A review of facility and resident records found no	A 123			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA		STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 123	Continued From page 13 documentation of reports to residents about the remaining balances or expenditures from their stimulus payment. Class III	A 123			
A 152 SS=I	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 height to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, chest of drawers, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 152	Continued From page 14 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 provide a safe living environment, free of hazards for 108 of 108 sampled residents (Residents #1 through 108). Three (3) out of 108 sampled residents, (Residents #1, #8 and #11) were specifically affected when the facility failed to immediately repair the roof after several complaints by residents over eight months of water intrusion to the resident's rooms, hallways, and ceilings. In addition, the facility failed to provide lamps for two out of 39 sampled residents, (Residents #23, and #24). Findings included: 1) Interviewed on at 7:45 am, Resident #1 stated since, water was coming through the electrical outlets in his private . . . # . Resident #1 stated further that the popcorn from the popcorn ceiling was falling on the floor due to the rain. Interviewed on at 7:15 am, Resident #8 stated that she was admitted to the facility in . . . and ever since then, when it rained, the ceiling would leak in the hallways. Resident #8 stated further, "During the rainy	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 15 season when it rains, the staff would place buckets in the hallway to catch the water." Observation at approximately 7:20 am of Resident #8's room () revealed sagging paint and another area of new paint where the resident indicated that a ceiling leak in the room to which she was located when her prior room flooded had caused more damage. Resident #8 stated that overall, her new unit was not well maintained, having ants in the shower and being insufficiently cleaned by the housekeeping staff. The resident stated that she hoped to be able to move soon and that she was afraid to voice any more concerns about her room due to her fears that the facility would kick her out. Observation on at 7:45 am found "Under Construction Signs" on # , # , # , and #59 due to a roof leak. . . . # , # , # were evacuated and unoccupied. A further observation showed substances resembling mold, mildew, and water marks in the ceilings and down the walls of . . . # . . . # . . . # . . . Photographic evidence was obtained. Interviewed on at 12:20 pm, the Maintenance Staff (Staff H) stated that the roofing problem began in . . . , and that they (administration) were trying to fix the problem since then. Interviewed on at 1:00 pm, when asked why the repairs had not been completed. The Maintenance Supervisor (Staff G), stated that the facility was still in the process of collecting bids from roofing companies, and that the facility was trying to stop the leaks with repairs done by maintenance staff (Staff G and H).	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA		STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 16 Interviewed on _____ at 12:00 pm, the Financial Director (Staff F) stated, "We have been trying to move Resident #1 since _____, but he refused. The ceiling was leaking bad since _____, We started to get it repaired before _____. We moved residents from # ____ # _____. We have a contractor now and the roof would be fixed after the holidays." Interviewed on _____ at 3:22 pm, the Administrator stated, "We were trying to get the roof done as soon as possible. We got a quote last week." A review of the roofing invoice for \$6,000 dated on _____ showed that the roofing leaks existed since 2020. A further review found new proposals to repair the roof dated _____ and another one to repair all leaks dated for \$43,000.00. There was no documentation about repairs or repair proposals between _____ and _____. 2) Observation on _____ at 7:30 am, found _____ # _____ belonging to Residents #23 and #24 without lamps (2) for their nightstand. Interviewed on _____ at 7:30 am Staff N (Housekeeper) stated, "They don't have lamps." Interviewed on _____ at 3:18 pm, the Administrator mentioned that she was aware that the rooms were without lamps	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

15520 NW 2 AVENUE

NORTH MIAMI BEACH, FL 33160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 17	A 152		
A 162 SS=D	Class II 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 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	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 18 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 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	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2022
NAME OF PROVIDER OR SUPPLIER COURTYARD PLAZA		STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 162	Continued From page 19 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., 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.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COURTYARD PLAZA

15520 NW 2 AVENUE

NORTH MIAMI BEACH, FL 33160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 20 (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: Based on record review and interview, the facility failed to ensure a completed health assessment was on _____ for one (#16) out of 39 sampled residents. Findings: A review of Resident #16's Health Assessment of Resident completed on _____ showed that the sections for "Nursing/Treatment/Service Requirements" and "Special Precautions" were both left blank. Interviewed on _____ at 3:22 PM, the Administrator acknowledged that sections of Resident #16's health assessment were left blank. Class III	A 162		