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
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 077 SS=I	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must:	A 077		

AHCA Form 3020-0001

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 077	Continued From page 1 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 077	Continued From page 2 facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not . . . . . , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, ... , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have an administrator capable of handling the operation and	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 077	Continued From page 3	A 077		

maintenance of the facility, including the management of all staff and the provision of appropriate care to all residents.

Findings included:

1)
A review of the background screening database showed that the Administrator was the facility's administrator since .

Review of facility's records showed a "Delegation of Authority" document posted inside the office for Staff B (office clerk).

On at 7:10 AM, Staff B stated that she started working in the facility in , prior to that she was working as a consultant. When asked if she was CORE certified, Staff B stated, "I do not have the CORE because I am not yet."

2)
On at 12:10 PM, Staff B stated that Resident #2 was admitted to the facility on and eloped the next day, . She further stated that they noticed Resident #2 was not in the facility in the morning during breakfast. Immediately, they started the search for the resident and called the police. Staff B further stated that the overnight staff (Staff C) was the last person who saw the resident during the night rounds. She explained that during the night, rounds were done every 2 hours and during the day every 3 hours. Finally, she informed that the police found Resident #2 at the hospital, and she did not know how the resident got there.

Review of hospital records revealed that Resident #2 was admitted after the fire rescue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 077	Continued From page 4 found the resident on the street with a . . . injury and discharged to the facility on . However, the records revealed that Resident #2 was also admitted under the same conditions. According to the records, Resident #2 left the facility and did not return. The fire rescue brought him to the emergency department with a injury after a . On at 7:20 AM, Staff B stated that it had not been another elopement and Resident #2 only eloped on . Staff B could not explain why Resident #2 was in the hospital for a second time from to . On at 2:20 PM, during a telephone interview with the Chief from the fire rescue, the Chief informed that there were two calls regarding Resident #2. Both calls involved . . when the resident was away from the facility. During the first call, Resident #2 was at a local gas station and down. Possible because the resident was in his 80's, his skin was "paper thin", so the resulted in a two-inch . During the second call, Resident #2 was walking around the area and was pushing a friend in a wheelchair, when he and injured himself again. Finally, the Chief said that there were no calls at the facility centered around Resident #2, so apparently the facility did not actually call rescue for the resident at any time. 3) On at 5:41 AM, during an interview, Resident #6 stated that he was involved in an incident with Resident #4 about two nights earlier. Resident #6 explained that he was alone on the front porch when Resident #4 began insulting him and threw a metal waste basket at him. Resident #6 stated that he covered his with his arms	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 077	Continued From page 5 and punched Resident #4. Afterwards, Resident #6 said that he asked staff on duty to call the police. He stated that the staff told him she could not call the police, instead she had to call the Owner. Resident #6 said that later Resident #4 called the police and when they arrived, the police talked to him [Resident #6]. Then, Resident #4 became violent, and the police took him away. On at 10:17 AM, Staff F (caretaker) stated that sometimes residents could get into fights, verbal or physical. She further stated that she witnessed one recently in which Resident #1 and Resident #4 were exchanging words. She said that could not remember exactly the date but occurred in the dining area during the morning. Staff F stated that she was standing close talking with someone. Then, she saw that the chair moved but did not see who pushed who. Immediately, she stopped between the residents and told them to stop, which they did. Staff F stated, "It did not go any further, there was no police involved and no one went to the hospital." On at 9:47 AM, during a telephone interview regarding the residents' altercation, Staff C (overnight shift caretaker) stated that he only had seen an incident between residents that occurred about a week earlier. Staff C explained that a resident who was no longer at the facility but could not remember his name threw an ashtray to Resident #6. Staff C further stated that his only intervention was to take away the ashtray and nothing further happened. 4) On at 5:30 AM, observation revealed the sink in residents' bathroom was detaching from the wall and at risk of falling. Further observation showed residents were using the	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 077	Continued From page 6 bathroom. On [redacted] at 10:10 AM, observation revealed a large puddle of water on the floor of the second-floor stairs landing. Further observation revealed that the water was coming from the air conditioner. Residents were passing through the area to use the stairs and there were no "wet floor warning" signs. On [redacted] at 10:55 AM, Staff B stated that the building's owner was aware of the water leak and was taking care of it. Staff B also stated that the air conditioner [AC] needed service and it would be fixed. Staff B further stated that they could not [redacted] the stairs because it was a fire exit and warning signs could not be used because the residents would take them. When asked regarding the falling sink in the residents' bathroom, Staff B stated that the Owner was aware of it. On [redacted] at 10:16 AM, during a telephone interview, the Administrator stated that Resident #2 only had eloped once. Additionally, she stated that she did not know anything about an assault. She stated that she interviewed all the residents, and nobody said anything. Also, the Administrator stated that she was aware there was a leak on the roof. She said that the owners of the property knew about the issues, and they had called them. Class II	A 077		
A 078 SS=D	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	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 7 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. 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	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 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, 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 interview and record review, the facility provided no documentation of a negative examination from a health care provider within 30 days of hire for seven out of eleven sampled staff (Staff B, C, E, F, H, J, and K) Findings included: Personnel records review of Staff B showed no documentation of a physical and examination stating that were free of any communicable . . . . Staff B's hire date was on . . . . . . Personnel records review of Staff C showed no	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 documentation of a physical and examination stating that were free of any communicable. Staff C's hire date was on . Personnel records review of Staff E showed no documentation of a physical and examination stating that were free of any communicable. Staff E's hire date was on . Personnel records review of Staff H showed no documentation of a physical and examination stating that were free of any communicable. Staff H's hire date was on . Personnel records review of Staff J showed no documentation of a physical and examination stating that were free of any communicable. Staff J's hire date was on . Personnel records review of Staff K showed no documentation of a physical and examination stating that were free of any communicable. Staff K's hire date was on . Personnel record review of Staff F showed expired documentation of a physical and examination. Last examination on file revealed it was dated . Staff F's hire date was on . On at 7:12 a.m. Staff B stated "I do not have my physical/ exam yet. For the other staff, if it's not on their record, they do not have it."	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 10 Class III	A 078		
A 079 SS=I	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 . — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 11 solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 12 decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 13 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have enough qualified staff to provide resident supervision, and to provide resident services in accordance with the residents' scheduled and unscheduled service needs. The facility failed to maintain a minimum of 294 staff hours per week for a licensed capacity of 30 residents.	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 14 Findings included: 1} On at 12:10 PM, Staff B (Administrator's designee) stated that Resident #2 was admitted to the facility on and eloped the next day, . She further stated that they noticed Resident #2 was not in the facility in the morning during breakfast. Immediately, they started the search for the resident and called the police. Staff B further stated that the overnight staff (Staff C) was the last person who saw the resident during the night rounds. She explained that during the night, rounds were done every 2 hours and during the day every 3 hours. Finally, she informed that the police found Resident #2 at the hospital, and she did not know how the resident got there. Review of hospital records revealed that Resident #2 was admitted after the fire rescue found the resident on the street with a injury and discharged to the facility on . However, the records revealed that Resident #2 was also admitted under the same conditions. According to the records, Resident #2 left the facility and did not return. The fire rescue brought him to the emergency department with a injury after a . A review of Resident #2's record showed no health assessment on file. On at 7:20 AM, Staff B stated that there had not been another elopement and that Resident #2 only eloped on . Staff B could not explain why Resident #2 was in the hospital for a second time from to .	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 15 A review of the employee schedule from . . . . . to . . . . . revealed that the total weekly staff hours were 226. The staffing pattern showed that a clerical staff was scheduled Sunday to Friday from 8:00 AM-3:00 PM, one caretaker was scheduled Monday to Friday from 7:00 AM-3:00 PM and two caretakers from 3:00 PM-11:00 PM; one caretaker was scheduled seven days a week from 11:00 PM-7:00 AM. On Saturdays, one caretaker was scheduled from 7:00 AM-3:00 PM, another caretaker from 8:00 AM-4:00 PM, and one caretaker from 3:00 PM-11:00 PM. On Sundays, one caretaker was scheduled from 7:00 AM-3:00 PM and two caretakers from 3:00 PM-11:00 PM. On at 9:47 AM, during a telephone interview, Staff C (overnight shift caretaker) stated that his work schedule was Monday to Friday from 11:00 PM to 7:30 AM. During the night, he would do rounds and check every room to see if the residents were there. Staff C further stated that he knew Resident #2 eloped, but only once, and it was a couple of weeks earlier, but was not sure of the exact date. He said that he worked that day and saw Resident #2 for the last time at around 8:00-9:00 PM but could not remember exactly. When, asked if he had just said that his shift started at 11:00 PM, he said, "Yes, but I have different schedules." 2) On at 5:15 AM, observation showed Staff D (caretaker) was the only staff on duty with a census of 25 residents. On at 5:20 AM, Staff D stated that she was covering for someone that was working but had to leave because she had , . Staff D	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 16 further stated that the staff had left the day before at approximately 11:30 PM. Staff D informed that she lived in the facility, but her working hours were Monday to Friday from 7:00 AM-3:00 PM. 3) A review of the employee schedule from to revealed that the total weekly staff hours were 266. The staffing pattern showed that a clerical staff was scheduled Sunday to Friday from 8:00 AM-3:00 PM, two caretakers were scheduled Monday to Friday from 7:00 AM-3:00 PM and two from 3:00 PM-11:00 PM; one caretaker was scheduled seven days a week from 11:00 PM-7:00 AM. On Saturdays, one caretaker was scheduled from 7:00 AM-3:00 PM, another caretaker from 8:00 AM-4:00 PM, and one caretaker from 3:00 PM-11:00 PM. On Sundays, one caretaker was scheduled from 7:00 AM-3:00 PM and two caretakers from 3:00 PM-11:00 PM. 4) On at 5:41 AM, during an interview, Resident #6 stated that he was involved in an incident with Resident #4 about two nights earlier. Resident #6 stated that he was alone on the front porch when Resident #4 began insulting him and threw a metal waste basket at him. Resident #6 stated that he covered his with his arms and punched Resident #4. Afterwards, Resident #6 said that he asked staff on duty to call the police. He stated that the staff told him she could not call the police, and said that instead she had to call the Owner. Resident #6 further stated that later, Resident #4 called the police and when they arrived, the police talked to him [Resident #6]. Then, Resident #4 became violent, and the police took him away.	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 17 During interview on at 5:41 am Resident 6 further stated that there was a woman on duty the day of the ashtray incident, he referred to her as "the Cuban woman..." "Resident 6 stated that he asked the staff on duty, 'the Cuban woman' to call the police. He stated that she told him she could not call the police, that she had to call the owner. Resident 6 stated: 'the owner called and said not to call the police'. Resident 6 further stated that a nice tall Cuban man came in and introduced himself as the 'owner's husband' and talked to him for a while."Resident 6 did not mention Staff C when he related the incident during the interview. Facility Record review revealed no documentation that Staff C was onsite during the incident On at 9:47 AM, during a telephone interview regarding the residents' altercation, Staff C (overnight shift caretaker) stated that he only had seen an incident between residents that occurred about a week earlier. Staff C stated that a resident who was no longer at the facility whose name he could not remember threw an ashtray to Resident #6. Staff C further stated that his only intervention was to take away the ashtray and nothing further happened. A review of Resident #3's health assessment completed showed medical history and diagnoses of 's , , ( ), and , , ( ). Resident #3 required assistance with bathing, , self-care (grooming), toileting and transferring; and needed assistance with the self-administration of medication. A review of Resident #4's health assessment completed showed medical history	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 18 and diagnoses of [illegible] prostatic hyperplasia ([illegible]), [illegible] ([illegible]), [illegible], [illegible] ([illegible]), [illegible] nodule and [illegible]. Resident #4 needed assistance with the self-administration of medication. A review of Resident #5's health assessment completed [illegible] showed medical history and diagnoses of [illegible] ([illegible]), [illegible], [illegible] and major [illegible]. Resident #5 needed assistance with the self-administration of medication. A review of Resident 6's health assessment completed [illegible] showed a medical history and diagnoses of [illegible] ([illegible]) Type II, major [illegible], [illegible] D deficiency, [illegible] diastolic [illegible], and [illegible]. Resident #6 needed assistance with the self-administration of medication. A review of Resident #7's health assessment completed [illegible] showed medical history and diagnoses of [illegible] ([illegible]), under care of psychiatrist, diagnosis unknown. Resident #7 required supervision with ambulation and transferring; and needed assistance with bathing, [illegible], self-care (grooming), and needed administration of medication. A review of Resident #8's health assessment completed [illegible] showed medical history and diagnoses of [illegible] ([illegible]), [illegible] ([illegible]), [illegible], [illegible] ([illegible]), and [illegible] ([illegible]). Resident #8 needed assistance with the	A 079		

A 079 Continued From page 19 A 079

self-administration of medication.

A review of Resident #9's health assessment completed showed medical history and diagnoses of ( ) and . Resident #9 needed assistance with the self-administration of medication.

A review of Resident #10's health assessment completed showed medical history and diagnoses of , COVID-19, and . Resident #10 required assistance with ambulation, bathing, eating, self-care (grooming), toileting and transferring, and needed assistance with the self-administration of medication.

A review of Resident #11's health assessment completed showed medical history and diagnoses of and ( ). Resident #11 required supervision with self-care (grooming), toileting and transferring; and needed assistance with ambulation, bathing, , and with the self-administration of medication.

A review of Resident #12's health assessment completed showed medical history and diagnoses of ( ), and . Resident #12 needed assistance with bathing, and with the self-administration of medication.

A review of Resident #13's health assessment completed showed medical history and diagnoses of ( ), ( ), and . Resident #13 required assistance with the self-administration of medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 20 A review of Resident #14's health assessment completed showed medical history and diagnoses of affective and . Resident #14 required supervision with self-care (grooming) and needed assistance with the self-administration of medication. A review of Resident #15's health assessment completed showed medical history and diagnoses of and . Resident #15 needed assistance with the self-administration of medication. A review of Resident #16's health assessment completed showed medical history and diagnoses of ( ), , pre- ( ), of , ( ), and . Resident #16 needed assistance with the self-administration of medication. A review of Resident #17's health assessment completed showed medical history and diagnoses of ( ), ( ), and enlarged . Resident #17 required assistance with the self-administration of medication. A review of Resident #18's health assessment completed showed medical history and diagnoses of ( ), ( ), ( ), and . Resident #18 needed assistance with the self-administration of medication.	A 079		

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
	AL11964887	A. BUILDING: ______ B. WING ______	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 21 A review of Resident #19's health assessment completed showed medical history and diagnoses of ( ) and 's . Resident #19 needed assistance with the self-administration of medication. A review of Resident #20's health assessment completed showed medical history and diagnoses of , ( ), ( ), (HLD), prostatic hyperplasia ( ), and (OA) of the . Resident #20 needed assistance with the self-administration of medication. A review of Resident #21's health assessment completed showed medical history and diagnoses of II ( ), ( ), and . Resident #21 needed assistance with bathing and with the self-administration of medication. A review of Resident #22's health assessment completed showed medical history and diagnoses of ( ), ( ) and ( ). Resident #22 required assistance with bathing, , self-care (grooming), and transferring; and needed assistance with the self-administration of medication. A review of Resident #23's health assessment completed showed medical history and diagnoses of ( ) and ( ). Resident #23 needed assistance with bathing and with the self-administration of medication.	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 22 A review of Resident #24's health assessment completed [redacted] showed medical history and diagnoses of [redacted] use [redacted] and [redacted]. Resident #24 needed assistance with the self-administration of medication. A review of Resident #25's health assessment completed [redacted] showed medical history and diagnoses of [redacted] pectoris, replacement, [redacted]. Resident #25 required supervision with ambulation and transferring; and needed assistance with bathing, [redacted] toileting and with the self-administration of medication. A review of Resident #26's health assessment completed [redacted] showed medical history and diagnoses of [redacted] and [redacted] decline (memory [redacted]). Resident #26 needed assistance with the self-administration of medication. A review of Resident #28's health assessment completed [redacted] showed medical history and diagnoses of [redacted]. Resident #28 needed assistance with the self-administration of medication. A review of Resident #29's health assessment completed [redacted] showed medical history and diagnoses of [redacted], balloon [redacted] angioplasty (BPA) and [redacted]	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 079	Continued From page 23 dependent . . . . . ( ). Resident #29 required assistance with ambulation, bathing, ..., self-care (grooming), toileting and transferring; and needed assistance with the self-administration of medication. On . . . . at 10:16 AM, during a telephone interview, the Administrator stated that Resident #2 only had eloped once. Additionally, she stated that she did not know anything about an assault. She stated that she interviewed all the residents, and nobody said anything. Class II	A 079		
A 090 SS=D	59A-36.011(11) FAC Training - (11) . . . . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . . . . . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . . within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one out of eleven sampled staff (Staff K) completed the one-hour training regarding . . . . . (. .)	A 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 090	Continued From page 24 within 30 days of employment. Findings included: Review of Personnel records for Staff K showed a hire date of . There was no documentation on file of the staff having completed the 1-hour training required regarding . . On at 7:12 a.m. Staff B, stated, "If it's not on their record, they do not have it." Class III	A 090		
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 form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services,	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 25 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 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.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 26 (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., 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	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 27 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: Based on record review and interview, the facility failed to provide an accurate and updated health assessment after a significant change of condition for one out of 37 sampled residents (Resident #2). Resident #2 eloped from the facility twice, on . . . . . and . . . . . Findings include: A review of the facility's admission/discharge log showed that Resident #2 was admitted on . . . . . . A review of Resident #2's record showed no health assessment. On at 12:10 p.m. Staff B stated "Resident #2 was admitted from [ ] Hospital and did not bring a health assessment. As of right now, there is no health assessment for him."	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 28 Class III	A 162		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 165	Continued From page 29 (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or	A 165		

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
	AL11964887	A. BUILDING: ______ B. WING ______	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 165	Continued From page 30	A 165		

through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The agency may adopt rules necessary to administer this section.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to submit an adverse incident report within one business day and within 15 days of the incident to the Agency for Healthcare Administration (AHCA) for two out of thirty-seven sampled residents (Resident # 2, #4 and #6). Resident # 2 eloped from the facility for the second time and was found by the local Fire Rescue department and transferred to a hospital on .... Resident # 4 and # 6 were involved in an assault at the facility which resulted in Resident #4 being hospitalized..

Findings include:

1)
A review of hospital records revealed that Resident #2 was brought to the emergency room by fire rescue again with a injury after a and was re-admitted on .... According to hospital records Resident #2 left the facility and did not return. Resident #2 stated that he was pushing a cart when he . Hospital records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 165	Continued From page 31 revealed a right forehead and a computerized (CT) scan showed acute findings, right frontal calvarial without underlying and mild burden of small and mild generalized parenchymal volume loss. Resident #2 was discharged to the facility on . A review of the online Adverse Incident Reporting System database showed no documentation the facility filed a one - day and a 15-day report to AHCA. During interview on at 7:20 AM, Staff B stated that Resident #2 had only eloped on and that there had not been any other incidents of elopement at the facility. Staff B could not explain why Resident #2 was admitted to the hospital for a second time from to . On at 7:20 a.m. Staff B stated, "Resident #2 is in the hospital. There has not been another elopement. He only eloped on ." 2) On at 5:41 AM, during an interview, Resident #6 stated that he was involved in an incident with Resident #4 about two nights earlier. Resident #6 stated that he was alone on the front porch when Resident #4 began insulting him and threw a metal waste basket at him. Resident #6 stated that he covered his with his arms and punched Resident #4. Afterwards, Resident #6 said that he asked staff on duty to call the police. He stated that the staff told him she could not call the police, and said that instead she had to call the Owner. Resident #6 further stated that later,	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 165	Continued From page 32 Resident #4 called the police and when they arrived, the police talked to him [Resident #6]. Then, Resident #4 became violent, and the police took him away. In an interview with Staff B on at 8:28 AM, Staff B stated that Resident #4 was in the hospital. A review of the online Adverse Incident Reporting System database showed no documentation the facility filed a one - day or a 15-day report to AHCA regarding the occurrence. Class III	A 165		
A 000	Initial Comments A complaint investigation (complaints #2022017860 and #2022017061) was conducted at Coral Sand, Inc from through . The provider had deficiencies identified at the time of the survey.	A 000		
A 025 SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 33 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 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 34 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision and to maintain a general awareness of one out of thirty-seven sampled residents (Resident #2). Resident #2 eloped from the facility twice within less than two weeks. Consequently, the resident was transferred to the hospital after the local fire rescue found him on the street after both elopements.. Also, the facility failed to maintain 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 for one out of thirty-seven sampled residents (Resident #1). Findings included: 1) A review of the Incident Report System (AIRS) revealed Resident #2 eloped from the facility on . The report showed that Resident #1 was last seen in the facility on approximately at 3:00 AM. On at 12:10 PM, Staff B (Administrator's designee) stated that Resident #2 was admitted to the facility on and eloped the next day, . She further stated that they noticed Resident #2 was not in the facility in the morning during breakfast. Immediately, they started the search for the resident and called the police. When the police arrived, they said that they could not file a missing	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 35	A 025		

person report until 24 hours later. Staff B further stated that the overnight staff (Staff C) was the last person who saw the resident during the night rounds. She explained that during the night, rounds were done every 2 hours and during the day every 3 hours. Finally, she informed that the police found Resident #2 at the hospital, and she did not know how the resident got there.

On at 2:54 PM, during an interview, Resident #2 stated that he had been living in the facility for about 3 months but did not know its name or address. Resident #2 stated that he did not have an identification only his social security card (Resident #2 showed his wallet where it was his social security card but no identification).

Review of hospital records revealed that Resident #2 was admitted after the fire rescue brought him to the emergency department with a injury. The records revealed that Resident #2 was found on the street, and he stated that he tripped and on a curb outside and hit his on the ground. Resident #2 had a above his right and left . The resident was noted to be slightly and upon reevaluation a alert was called for , tremor, and fasciculations. Resident #2 was discharged to the facility on .

Additional hospital records revealed that Resident #2 was also admitted when fire rescue brought him to the emergency department with a injury after a on the street. According to the hospital record, Resident #2 left the facility and did not return. The resident stated that he was pushing a cart when he . Resident #2 had a right forehead and a computerized (CT) scan showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 36 acute findings, right frontal calvarial without underlying skill and mild burden of small and mild generalized parenchymal volume loss. Resident #2 was discharged to the facility on . On at 7:20 AM, Staff B stated that it had not been another elopement and Resident #2 only eloped on . Staff B could not explain why Resident #2 was in the hospital for a second time from to . On at 9:47 AM, during a telephone interview, Staff C (overnight shift caretaker) stated that his work schedule was Monday to Friday from 11:00 PM to 7:30 AM. He stated that during the night, he would conduct rounds and check every room to see if the residents were there. Staff C further stated that he knew Resident #2 eloped, but only once, and it was a couple of weeks earlier, but he was not sure of the exact date. He said that he worked that day and saw Resident #2 for the last time at around 8:00-9:00 PM , although he could not remember exactly what time. When, asked if he had stated moments earlier that his shift started at 11:00 PM, he said, "Yes, but I have different schedules." On at 2:20 PM, during a telephone interview with the Chief from the fire rescue, the Chief stated that there were two calls regarding Resident #2. He said that both calls involved when the resident was away from the facility. He further stated that during the first call, Resident #2 was at a local gas station and down. He stated that, possibly because the resident's age was in his 80's, his skin was "paper thin", so the resulted in a two-inch . The Chief stated that during the second call, Resident #2	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 37 was walking around the area and was pushing a friend in a wheelchair, when he and injured himself again. Finally, the Chief said that there were no calls at the facility centered around Resident #2, so apparently the facility had not called rescue for the resident at any time. A review of Resident #2's record showed no documentation of the second elopement and hospitalization. 2) On at 1:05 PM, Staff B (Administrator's designee) stated that Resident #1's medical were made automatically, and that the facility would receive a phone call from the medical provider or a mail notification. Staff B further stated that Resident #1 had recently missed one because he was refusing to go. Staff B stated the was on for labs prior to a procedure scheduled for , however, that day, , the resident was agitated and did not want to go. She stated that she contacted the scheduling department at the medical provider's office and scheduled Resident #1 to have everything done on the same day of the scheduled procedure, . Staff B stated that when the transportation arrived, the resident refused to go and the following day, , the facility sent him to the hospital because 'he did not look like himself.' On at 2:14 PM, when asked why there were no progress notes on Resident #1's record about refusing to go to medical , Staff B stated that she was waiting for the resident to come from the hospital to put all the information at once.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 38 On ... . at 11:50 AM, during a telephone interview with Resident #1's case manager, she stated that Resident #1 had missed several medical , , . The case manager stated that she had spoken with the Owner who told her that she had been trying to get the resident to the hospital, but he had been refusing. Then, she spoke with Staff B who said that the resident had not been refusing and she would be rescheduling his , , . However, when she spoke with Resident #1 and asked him about his missed , , , the resident said that nobody told him about any , , , ... Also, the case manager stated that she was aware that Resident #1 was in the hospital since ..... She stated that the Owner told her that they called 911 because that resident was sweaty and clammy. However, Staff B had told the case manager that she believed the resident had a ..... . Review of hospital records revealed that Resident #1 was admitted to the hospital on due to ..... . The records indicated that paramedics arrived at the facility and found out the Resident #1 had a focal right-sided ..... lasting approximately 10 minutes. On at 7:13 AM, during a second interview, Staff B stated that Resident #1 was transferred to the hospital on because he was 'down', clarifying that she meant not active, and was not walking well. She further stated that she called 911 and when the rescue arrived, they placed him on an ( ) and took him to the hospital. She added, "He did not have a , I know that because they did not tell me that." A review of Resident #1's health assessment completed showed medical history	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 39 and diagnoses of . . . . . ( ), , , ( ), , , ( ), , ... and , , . Resident #1 needed assistance with the self-administration of medication. Further review of Resident #1's record revealed no documentation of the hospitalization nor the missed medical , , . Class II	A 025		
A 027 SS=G	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , ... for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to arranged health care for one out of 37 sampled residents (Resident #4). The resident did not received his medications from . . . . . to leading to a deterionaton of the chnonic mental health condition.	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 027	Continued From page 40 Finding Include: A review of Resident #4's Demographic Information showed that the resident was admitted to the facility on . A review of Resident #4's Health Assessment dated ....., it showed that the resident had a medical history and diagnoses of , , , Prostatic Hyperplasia ( ), , , , Nodule, , , and history of sleep , . As for or behavioral status, the resident was alert and orientated x3 (person, place, and time). A review of Resident #4's Medication Observation Record (MOR) for the months of and , it showed that the resident started refusing his medications on . This refusal continues until at which time the resident was transferred to the hospital. The resident refused the following medications: 1. , 2.5 mg take one tablet once a day. used to treat high , . 2. 80 mg take one tablet once a day. used to treat high . 3. D 50mcg take one tablet once a day. 4. , 10mg take one tablet once a day. Is an , , medication that is used to treat , , conditions such as , and , . 5. 2mg take one capsule once a day. Used to treat high , . 6. Caridopa Levidopa 25/100 mg take one tablet twice a day. Used to treat symptoms of such as stiffness or tremors. 7. 10gm/15ml take 15ml once a day.	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 027	Continued From page 41 Used to treat [illegible] (ammonia inhibitor). 8. [illegible] 100mg take one tablet once a day. Used to treat [illegible] B1 deficiency. 9. [illegible] 300mg take one tablet twice a day. Used to treat high [illegible]. 10. [illegible] 500mg take 4 tablets at bedtime. Used to treat [illegible] episodes related to [illegible]. A review of Resident #4's Observation Log dated [illegible] revealed that Resident #4'srefused to take his medications. Doctor was called and notified. There was no documentation of the name of the doctor that was notified and if any order were given. A review of Resident #4's Observation Log dated [illegible] revealed that Resident #4'srefused to take his medications. Doctor was called and notified. Resident is causing arguments with other residents at the facility. There was no documentation of the name of the doctor that was notified and it any orders were given. A review of Resident #4's Observation Log dated [illegible] revealed that the Administrator met with the resident fiduciary guardian. They discussed the resident refusal to take his medications because "life is better without medications, and he was also consuming [illegible]. A review of Resident #4's Observation Log dated [illegible] revealed "resident was drinking liquor on the porch and attempted to give it to the residents. Staff quickly took the bottle away. He is verbally aggressive with the Administrator and residents".	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 027	Continued From page 42 A review of Resident #4's Observation Log dated revealed "placed a call with his doctors at the Veteran Affairs (VA)hospital because the resident is saying he was told by a doctor that he no longer has to take medication". There was no documentation whether the facility received any instructions or orders from the resident primary care provider. A review of Resident #4's Observation Log dated revealed "resident refused to take medication. Doctor was called and notified. He on himself and refused to clean up". There was no documentation of the name of the doctor that was notified and if any orders were given. A review of Resident #4's Observation Log dated revealed "resident refused to take medication. Doctor was called and notified. He is refusing to bath and clean up". There was no documentation whether the facility received any instructions or orders from the resident primary care provider. A review of Resident #4's Observation Log dated revealed 'Administrator spoke with Resident #4'sfiduciary guardian to transfer the resident to the hospital on . A review of Resident #4's Observation Log dated revealed "he was sent to the VA. After he arrived at the VA, we spoke with the doctor, and she said that they are going to keep him in observation and medicate him". In an interview with Staff B on at 8:28 AM, Staff B stated that Resident #4 was refusing medications. She said, "He was trying to drink in the facility and was verbally aggressive	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 027	Continued From page 43 toward the Administrator and residents. The Administrator (Administrator) was in contact with his fiduciary and his sister-in-law who is his only relative. We send him to the VA hospital on . . . . . ." In an interview with Resident #4's Fiduciary Payee on at 2:31 PM, regarding Resident #4, He stated, "He has been so difficult that I think he may need to go to a State Hospital. I spent an hour on the phone with him and his sister trying to convince him to take his medications. There was nothing that we could do, he said that the medication is poison". In an interview with the Administrator on at 4:12 PM, the Administrator stated that Resident #4 was still in the hospital. In an interview with Staff B on at 12:45 PM, Staff B stated that she called Resident #4's physician regarding the resident refusing his medications and his behavioral changes. She stated she did not remember the physician's name. According to Staff B, she did not receive any orders except for the last time she phone the VA hospital. She was told to the resident, but she did not do it. When asked when and who ordered the . . . . ., she stated did not remember. Class II	A 027		
A 030 SS=D	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 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 44 (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. (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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 45	A 030		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 46 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 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.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 47 (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 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 48 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, [illegible], and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 49 possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide supervision during an assault between 2 Residents (#4 and #6). The facility also failed to provide the residents a 45 days' notice of relocation or termination of residency from the facility for eight out of thirty-seven (Resident # 30, 31, 32, 33, 34, 35, 36, and 37) sampled residents. Further review showed the facility also failed to provide a working telephone accessible to all residents. Findings included: 1) ... . at 5:41 a.m. during an interview with Resident #6, when asked about incidents at the facility, Resident #6 stated that he was involved in an incident with Resident #6 about two nights ago, "it was late." Resident #6 related that he was alone on the front porch when Resident #4 began insulting him and threw a waste basket at him. Resident #6 also stated that he covered his	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 50 . . . with his arms and then punched resident #4. Resident #6 stated that resident #4 is always very rude and aggressive: "he insults people". Resident #6 stated that he asked the staff on duty, Staff J, to call the police. Resident #6 continued stating that Staff J told him she could not call the police, that she had to call the owner. Resident #6 stated: "the owner called and said not to call the police". Resident #6 also stated that sometime later resident #4 called the police and "they talked to me but did not take me". Resident #6 further stated that resident #4 "became violent and four policemen carried him away, he has not returned, he is at the [ ] hospital now". Resident #6 stated that staff J took pictures of Resident #4. at 6:07 a.m. during an interview with Resident #10, he stated regarding the incidence of violence between Residents # 4 and 6, "I don't know what happened because they had the door closed. This happened the day before yesterday at around 6:15 a.m. When asked how many staff members are in the facility during the night shift, he stated, "Only one." at 6:11 a.m. during an interview with Resident # 27, she stated, "I did not see a fight, but I heard someone saying something about it." When asked how many staff members are in the facility during the night shift, she stated, "Only one staff. " at 9:50 a.m. during an interview with Resident # 15, when asked how many staff members are in the facility during the night shift, she stated, " only one." at 9:52 a.m. during an interview with Resident #5, when asked how many staff	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 51 members are in the facility during the night shift, she stated, "Always one stays here" at 9:54 a.m. during an interview with Resident 21 when asked how many staff members are in the facility during the night shift, he stated, "Always one, only girls." at 9:57 a.m. during an interview with Resident #19 when asked how many staff members are in the facility during the night shift, he stated "just one awake, the other one is in her room." at 10:05 a.m. during an interview with Resident #20, when asked how many staff members are in the facility during the night shift, he stated, "1 staff is up doing shores, the other one is in her room. at 10:08 a.m. during an interview with Resident #17, when asked how many staff members are in the facility during the night shift, he stated "One, only females at night." at 9:47 a.m. during a telephone interview with Staff C regarding the assault, he stated, "He (Resident #4) threw the ashtray to another Resident, (Resident #6), I took away the ashtray." at 10:30 a.m. during a telephone interview when asked about the assault between Resident #4 and Resident #6, the Administrator stated that she was not aware of any assault incidents at the facility. When asked the reason resident #4 was hospitalized, the Administrator stated "for evaluation and treatment."	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 52 2) A review of Resident #30's record showed he was admitted on and had a diagnosis of ( ) NAFLD (fatty), Tobacco use, managed by long term injections. needs assistance with ADL's, The Health Assessment dated indicated the resident needed assistance with bathing and self-care, independent with ambulation, eating, toileting and transferring. Needs assistance with Self-Administration of medications. Further review of Admission and Discharge log showed Resident # 30 was discharged from the facility to [ ] Hospital on due to disorientation and getting worse. No records found on file of a 45 days' notice of relocation or termination of residency from the facility was provided to the resident. A review of Resident #31's records showed he was admitted on and discharged on to [ ] Hospital due to . According to the record, the resident never returned. There was no documentation from a physician that the resident needed a higher level of care after being stabilized during the hospitalization. Further review of records showed no Health Assessment for Resident #31 on file. No records found on file of a 45 days' notice of relocation or termination of residency from the facility was provided to the resident. A review of Resident #32's records showed he was admitted on and discharged on to [ ] Hospital due to . There was no documentation from a physician that the resident needed a higher level of care after being stabilized during the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 53 hospitalization. Further review of records showed no Health Assessment for Resident #33 on file. No records found on file of a 45 days' notice of relocation or termination of residency from the facility was provided to the resident. A review of Resident #33's records showed she was admitted on and has a diagnosis of , , (,), (,). The Health Assessment dated indicated the resident needed supervision with ambulation, bathing, , dependent with eating, self-care, and toileting. Needs assistance with Self-Administration of medications. Further review of the Admission and Discharge log showed Resident # 33 was discharged from the facility to [ ] Hospital on . There was no documentation from a physician that the resident needed a higher level of care after being stabilized during the hospitalization. No records were found of a 45 days' notice of relocation or termination of residency from the facility being provided to the resident. A review of Resident #34's records showed she was admitted on and discharged on to [ ] Hospital due to . Further review of records showed no Health Assessment on file. No records found on file of a 45 days' notice of relocation or termination of residency from the facility was provided to the resident. A review of Resident #35's records showed he was admitted on and has a diagnosis of Type II , History of GSW (gunshot) to and . The health assessment dated on indicated the resident needed assistance with	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 54 Needs Assistance with Ambulation, bathing, , eating, self-care, toileting, and transferring. Diet of calorie controlled and no added salt and needs assistance with Self-Administration of medications. Further review of the Admission and Discharge log showed Resident # 35 was discharged from the facility to [ ] Hospital on . No records found of a 45 days' notice of relocation or termination of residency from the facility was provided to the resident. A review of Resident #36's records showed he was admitted on and has a diagnosis of , , abnormalities of gait and mobility. Physical limitations of unsteady gait with history of . Low concentration, low memory. General precautions, The Health Assessment dated indicated the resident needed supervision with ambulation, bathing, , self-care, toileting and transferring. Independent with eating. And needs assistance with Self-administration medications. Further review of the Admission and Discharge log showed Resident # 36 was discharged from the facility to [ ] Hospital on . No records found of a 45 days' notice of relocation or termination of residency from the facility was provided to the resident. A review of Resident #37's records showed he was admitted on and has a diagnosis of Type II , , , , MDD (Major ,), , Hypertensive , ( ), . The Health Assessment dated indicated the resident needed monitoring with	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 55 medication compliance and overall health status, independent with all activities of daily living, Further review of the Admission and Discharge log showed Resident # 37 was discharged from the facility to [ ] Hospital on [redacted] due to [redacted]. No records found of a 45 days' notice of relocation or termination of residency from the facility was provided to the resident. On [redacted] at 10:23 a.m. during an interview with Staff B stated "no one has been provided with a 45 days' notice letter." 3) On [redacted] at 11:13 a.m. Observed the phone provided for the Residents on the first floor was not in working condition, further observation revealed there was no phone on the second floor. On [redacted] at 11:41 a.m. during an interview with Staff B stated "the residents broke it again; this has happened before" Class II	A 030		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 032	Continued From page 56 a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 032	Continued From page 57 response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to follow its policies and procedures regarding resident elopement when one of thirty-seven sampled residents eloped from the facility. (Resident#2) Resident #2 was hospitalized after he was found on the street by fire rescue. Findings: A review of the Incident Report System (AIRS) revealed Resident #2 eloped from the facility on . . . . . The report showed that Resident #1 was last seen in the facility on at around 3:00 AM. During interview on . . . . . at 12:10 PM, Staff B (Administrator's designee) stated that Resident #2 was admitted to the facility on . . . . . and eloped the next day, . Staff B further stated that the staff noticed Resident #2 was missing on in the morning during breakfast. They immediately proceeded to search for the resident and called the police. Staff B	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 032	Continued From page 58 stated that the police told them that they could not file a missing person report until 24 hours later. Staff B further stated that Resident #2 was last seen by the night staff (Staff C) during rounds. Staff B stated that night rounds are done every 2 hours. Staff B further stated that Resident #2 was found at the hospital by the police. During interview on [redacted] at 2:54 PM, Resident #2 stated that he had lived in the facility for about 3 months but was not able to say its name or address. Resident #2 stated that he did not have an identification, only his social security card (Resident #2 showed his wallet with his social security card but there was no identification). Review of hospital records revealed that Resident #2 was admitted to the hospital on [redacted] after he was brought by fire rescue to the emergency department with a [redacted] injury. Hospital records revealed that Resident #2 was found on the street, and he stated that he tripped and [redacted] on a curb outside hitting his [redacted] on the ground. Hospital records revealed that Resident #2 presented a [redacted] above his right [redacted], and a [redacted] on his left [redacted]. Hospital records describe Resident #2 mental status as slightly [redacted] and upon reevaluation a [redacted] alert was called due to [redacted], tremor, and [redacted] fasciculations. Hospital records showed that Resident #2 was discharged to the facility on [redacted]. A review of additional hospital records revealed that Resident #2 was brought to the emergency room by fire rescue again with a [redacted] injury after a [redacted] and was re-admitted on [redacted]. According to hospital records Resident #2 left the	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 032	Continued From page 59 facility and did not return. Resident #2 stated that he was pushing a cart when he . Hospital records revealed a right forehead and a computerized , , (CT) scan showed acute findings, right frontal calvarial without underlying and mild burden of small and mild generalized parenchymal volume loss. Resident #2 was discharged to the facility on . During interview on at 7:20 AM, Staff B stated that Resident #2 had only eloped on and that there had not been any other incidents of elopement at the facility. Staff B could not explain why Resident #2 was admitted to the hospital for a second time from to . A record review revealed that Resident #2 was admitted to the facility on from [ ], a behavioral hospital. A review of Resident #2's the behavioral hospital record showed a history and symptoms of "Disorientation, and resulting in significant loss of functioning" A review of Resident #2's record revealed no documentation of the second elopement and hospitalization. Further review showed no health assessment, no individualized plan of care and no Wondering Risk Scale form completed. A review of the facility's Elopement Policies and Procedures reveals the following policy: "All new residents will be assessed for elopement risk prior to admission to the facility. All residents at risk of elopement shall be identified so the staff can be alerted to their needs for support and	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 032	Continued From page 60 supervision." Further review showed that the facility's Elopement Policies and Procedures also stated that: Policy: 1 As part of admission assessment, all newly admitted Resident's clinical status will be assessed by the facility administrator to determine their risk for ˘ using the ˘ Risk Scale form. a. Reassessed prior to or on admission. ii. Whenever there is a change in Resident's clinical status. 2. Residents who are identified at risk to and high risk to must have an individualized plan of care. Purpose: To establish uniform guidelines in identifying and providing safety to all Residents at risk of . Class II	A 032		
A 054 SS=E	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 054	Continued From page 61 offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate and up-to-date Medication Observation Records (MOR) for 16 out of 37 sample residents (Resident #1, #4, #5, #8, #9, #12, #13, #17, #18, #20, #21, #24, #25, #26, #27, #28). Finding include: A review of Resident #28 MOR for [illegible], the MOR did not include the physician's name and telephone number. The [illegible] 4mg/spray one spray through the [illegible] as needed for [illegible] overdose was not listed in the MOR. The name of the resident should be written on every MOR. The direction of used should not include abbreviations such as PO, QD. A review of Resident #17 MOR for [illegible], it showed that the staff did not document whether the resident received his medication on [illegible] at 8 AM	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 054	Continued From page 62 A. [redacted] 50mg take one tablet daily (8 am)- B. Vesicare 10mg one tablet by [redacted] daily (8 am)- C. [redacted] 50mg take one tablet twice daily (8 am)- D. [redacted] 400 mg take one table twice daily (8 am)- E. Anoro Eppipta 62. [redacted] mcg inhale one puff by [redacted] once daily- [redacted] to A review of Resident #26 MOR for [redacted], it showed that the facility did not sign the MOR for the following medication on [redacted] at 8 am: [redacted] 50mg take one tablet by [redacted] twice a day. A review of Resident #18 MOR for [redacted], it showed that the MOR was missing the physician's name and telephone number. Need to write the direction of used without abbreviations. The resident name was not written in each MOR. A review of Resident #20 MOR for [redacted], it showed that the MOR was missing the physician's name and telephone number, the name of the resident on each MOR, and need to write direction of use without using abbreviations. A review of Resident #27 MOR for [redacted], it showed that there was no documentation that the resident was given [redacted] 100 units inject 15 units SQ at bedtime from [redacted] to [redacted]. The MOR was missing the physician's telephone number. A review of Resident #25 MOR for [redacted], it showed that the MOR was missing the physician's name and telephone number, and the resident name on each MOR.	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 054	Continued From page 63 A review of Resident #1 MOR for , it showed that the MOR was missing the physician's name and telephone number, the resident name on each MOR, and the direction of use without the use of abbreviations A review of Resident #8 MOR for , it showed that the MOR was missing the physician's name and telephone number, the name of the resident on each MOR, and clear direction of use without using abbreviations. A review of Resident #12 MOR for it showed that the MOR was missing the physician's name and telephone number, clear direction of use without abbreviations, and the name of the resident on each MOR. The as need (PRN) medication order was not written in the MOR. A review of Resident #13 MOR for , it showed that the MOR was missing the physician's name and telephone number, clear directions of use without abbreviations, and the resident name on each MOR. A review of Resident #24 MOR for , it showed that the MOR was missing the physician's name and telephone number, the resident name on each MOR, and clear direction of use without the used of abbreviations. A review of Resident #5 MOR for , it showed that there was no documentation of whether the resident was given the following medication: Solution 0.005% instill one drop into both every evening (4 pm) from to	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964887	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL SAND INC	7800 ABBOTT AVENUE MIAMI BEACH, FL 33141

(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 054	Continued From page 64 A review of Resident #9 MOR for . . . , it showed that the MOR was missing the physician's name and telephone number, clear direction of use without abbreviations, and resident name on each MOR. A review of Resident #21 MOR for . . . , it showed that the MOR was missing the physician's name and telephone number, clear direction of use without the use of abbreviations, resident name on each MOR, and the PRN medications (, 500 mg take two tablets orally every 8 hours PRN and . . . . . 1% gel apply to skin three times a day PRN) were not listed in the MOR. A review of Resident #4 MOR for . . . , it showed that the MOR was missing the physician's name and telephone number, clear direction of use without abbreviations, and the resident name on each MOR. In an interview with Staff B on . . . . . at 11:48 PM, regarding the MOR deficiencies, Staff B stated that "I did not know that". Class III	A 054		