

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000}	Initial Comments A revisit to 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 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	{A 025}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being of one out of 38 sampled residents (Resident #2). The facility failed to implement measures to avoid the continuous elopement of residents with a history of Findings include: A review of Resident #2's hospital record dated showed a "gentleman brought in by	{A 025}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 2 police under the for acute Patient was found walking in the street with a trash bag full of his own belongings by police. When police told him they were going to be transporting him to the nursing home, the patient stated that he wanted to kill himself with a gun." A review of the agency's adverse incident database showed Resident #2 eloped from the facility on and In an interview on at 6:13 AM, when asked if Resident #2 was considered an elopement risk, Staff L, Assistant Administrator, stated, "No, there is no one here that is an elopement risk. Mentally [Resident #2] is not well, so we don't allow him to go out by himself." A review of progress notes dated showed at 4:20 PM, "[Resident #2] was saying that he was planning to leave the facility to get his money When the staff talked to him, he got agitated. The physician was called, and he suggested that he be transferred to the hospital for a medication evaluation." A review of Resident #2's progress notes showed no documentation of him from the facility. Further review showed no documentation that the facility contacted the resident's physician about Resident #2's attempts to elope and to seek guidance on preventing further occurrences. On at 3:38 PM, when asked about precautions after Resident #2 eloped from the facility, the Administrator stated, "We got him a bracelet with GPS." When asked for documentation of the measures in place, the Administrator said, "We didn't document it."	{A 025}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 3 A review of the agency's adverse incident database showed no documentation of the resident eloping from the facility on . During an interview on . at 3:35 PM, when asked about the elopement on ., the Administrator stated the resident had not eloped. When asked why she thought Resident #2 was transported to the hospital after being found on the street with a bag of his belongings, the Administrator stated, "It was from here that the police picked him up. He doesn't have any belongings. [Resident #2] was saying that he was leaving because he had to pick up his money. The police weren't called. They were doing rounds, and he was saying all the craziness, and they took him. He was outside the gate. We were trying to get him to come . inside." A review of a police report filed on . showed that at 4:43 PM, officers responded to a call of "an elderly male who appeared to be lost." Resident #2 was observed walking approximately 2.1 miles away from the location of the facility. When interviewed, the resident expressed that he was thirsty and was unable to provide information about himself. Resident #2 was then transferred to the hospital under a . after expressing to officers he wanted to commit . A review of Resident #2's record showed he was admitted on . The health assessment dated . showed a medical history and diagnoses of falling, . and . The resident was independent with ambulation, eating, toileting, and transferring and needed supervision with bathing, ., and grooming. The health assessment indicated that the resident was not an elopement risk.	{A 025}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 4 A review of Resident #2's records showed no documentation of the resident being reassessed after the elopement attempts. Uncorrected 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 assist with the arrangement of healthcare services for one out of 38 sampled residents (Resident #6). Resident #6 did not receive his medications from _____/3023 to _____ leading to his hospitalization on _____. Findings included: On _____ at 07:05 AM, Assistant Administrator stated that Resident #6 returned to	{A 027}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 5 the facility on and transferred ... to the hospital the same day because the resident wasn't following command. Assistant Administrator stated that Resident #6 also wasn't taking his medications. Assistant Administrator then stated, "No, he (Resident #6) came in the morning and transferred to the hospital in afternoon or the evening; I don't remember. He did not want to take his medications, and he looked We called ambulance, and he went to the hospital." Review of Resident #6's observation log dated showed that Resident #6 returned from the hospital. Further review showed that Resident #6 was transferred to the hospital on the same day because he was and was not taking his prescribed medications. However, review of facility's hospital log showed that Resident #6 was transferred to the hospital on due to and red and Resident #6 returned to the facility on Further review showed that Resident #6 was transferred to the hospital on due to mental altered status. Review of Resident #6's hospital record showed that the resident was admitted on at 12:06 PM. Resident #6 presented with and disorientation. According to the report, "patient with many conditions was brought to emergency room for evaluation due to reported with and disorientation. This was reported by ALF Staff. The patient has a significant decline in his and mental status over the last 7 to 10 days. The symptoms/episode began/occurred 7 days ago, and became worse today." Further	{A 027}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
{A 027}	Continued From page 6 review of the hospital report showed that on at 12:28 PM Resident #6 revealed, " (Resident #6) states that he is out of medications since Friday ()." Also the hospital report revealed that the resident was on home medications for: 325 MG 2 tablets twice a day, 12% lotion 1 application daily, 15 MG 1 tablet daily, 20 MG 1 tablet every night at bedtime, 1% gel 4 grams twice a day, 0.4 1 capsule every night at bedtime, 30 MG 1 capsule every night at bedtime, 100 MG 1 tablet every night at bedtime, 20 MG 1 tablet twice a day with empty D3 50 MCG (2000 unit) 1 tablet daily, 500 MG 1 tablet twice a day, 5MG 1 tablet daily, flutic/same aer twice a day inhale, 20 MG 1 tablet daily, 25 MG 1 tablet three times a day, 100 unit/mL (3 mL) 25 units daily, 0.005% 1 drop daily, 10 MG 1 tablet daily, 20 1000 MG 1 tablet twice a day, 50 MG 1 tablet twice a day, 2% 1 application daily. Review of Resident #6's medication observation record (MOR) showed that Resident #6 did not take any of his medications from to including all the medications listed on the hospital report. On at 03:16 PM, Administrator stated, "He (Resident #6) was declining. They wanted to change him like taking him out of PACE. PACE was disenrolling and enrolling him. The insurance was not able to fill the prescription. His medications came in on the 5th (). He didn't	{A 027}	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 7 have any medication. By the time the meds came, he was in the hospital. We were trying to deal with the pharmacy to get his medications even if it was for one day." However, a review of Resident #6's record found no documentation regarding communication between the facility and the pharmacy. Review of Resident #6's health assessment dated showed medical history and diagnoses of type II, major D deficiency, diastolic , and ; the resident needed assistance with self-administration of medications. Uncorrected Class II	{A 027}			
{A 030} SS=I	59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility	{A 030}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 8 policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96- _____ or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. _____ and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident _____, neglect, and _____; 6. Administrative and housekeeping schedules and requirements; 7. _____ control, sanitation, and 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	{A 030}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 9 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 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	{A 030}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 10 visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . 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	{A 030}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 11 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 ill, 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. (I) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without harassment, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, responsibilities, 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	{A 030}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 12 State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall 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	{A 030}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 13 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 ensure that two out of 38 sampled residents lived in a safe and decent living environment, free from and neglect (Resident #4 and #6). The facility failed to follow its written grievance procedure for receiving and responding to resident complaints. The facility failed to provide the residents with 45 days' notice of relocation or termination of residency for one out of 38 sampled residents (Resident #26). The facility also failed to have a telephone accessible to residents on each floor of the building. Findings include: A review of Resident #4's progress notes dated showed, "Resident was sitting outside smoking with another [Resident #6] when they began arguing over who was going to have the ashtray on their side. It was all verbal. The caretaker interviewed them and said to them that the ashtray was going to be in the middle for both of them and if they couldn't share, then they couldn't smoke together." In a prior interview with Resident #6 on at 5:41 AM, he stated that he and Resident #4 got into a physical altercation where he requested that staff call the police. A review of an adverse incident report filed on showed, "The facility administrator interviewed [Resident #6] and caretaker to understand facts of the supposed incident.	{A 030}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 14 According to interviews, he was never touched by another resident, nor did he go to a hospital, nor was law enforcement called. There is no outcome to describe what he claims happened to him." A review of the facility's complaint and grievance policy states, "A meeting must be held within one day of receipt of the grievance between the aggrieved person and the facility management. Investigate the accuracy of the Resident's statement, and the Administrator/Owner will discuss the problem and attempt to reach a solution satisfactory to all parties within 7 days. A written summary of the formal grievance heard by the Administrator/Owner will be recorded, which includes the nature of the grievance and remediation correction plan. The administrator or designee will complete the grievance log and record it in the grievance folder." A review of the grievance log showed no documentation of the incident between [Resident #4] and [Resident #6]. A review of the facility's records showed no documentation of an investigation into the incident. Also, there was no documentation that the Administrator spoke with Resident #4 and Resident #6 or their guardians regarding the incident. In an interview on _____ at 7:18 AM with Staff L, Assistant Administrator, when asked if the facility had any resident-on-resident _____/alterations, he stated, "No, but there are rules in the resident contract." A review of the facility records showed no documentation of rules concerning resident-on-resident _____/alterations in the	{A 030}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 15 Resident's contracts. There was no documentation of a meeting to inform the residents of the facility's tolerance of and altercations. On at 7:20 AM, Staff L stated, "Staff received training on what to do in case of an altercation between residents when I started working here on [Administrator] was giving the training." When asked for documentation of the training given to staff, Staff L said, "I can't say if there is any documentation." In an interview on at 8:15 AM, when asked if she received training on Resident altercations, Staff F stated, "No, I never received any training on that." 2) A review of the facility's admission/discharge log showed Resident #26 was admitted on /20022 and discharged on due to "wanting more independence". A review of Resident #26's progress notes showed no documentation of the resident's discharge from the facility. A review of Resident #26's record showed no documentation of a 45-day notice of relocation or termination of residency from the facility. In an interview on at 7:51 AM, when asked about Resident #26's discharge from the facility, Staff L, Assistant Administrator, stated, "She wanted to live alone. She went to live with her family. Her sister is preparing a house for her, but it's not ready, so she went to another assisted living facility; she will only be there for a month. [Administrator] doesn't remember the full name of the facility."	{A 030}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 16 3) On _____ at 5:15 AM, observed that the facility had a census of 22 residents in a 2-story building. Observed the facility had no telephone service on any of the floors. Observation also revealed the residents had no telephone services or any other device in their rooms to call for assistance. In an interview on _____ at 7:15 AM, when asked if a telephone was available for residents on the second floor, Staff D stated, "No, there is no telephone on the second floor, only on the first floor." Class II Uncorrected	{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 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.	{A 032}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 17 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case 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	{A 032}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 18 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 own elopement policy to identify one resident with a history of elopements out of thirty-eight sampled residents (Resident #2). The facility also failed to maintain a general awareness of the location of one out of thirty-eight sampled residents that was at risk of elopement and had eloped from the facility three times within a four week period (Resident #2). Findings: A review of the Incident Report System (AIRS), hospital records and local police report revealed that Resident #2 had eloped from the facility on _____ on _____ and on _____. A review of facility records showed that Resident #2 was not identified as an elopement risk to alert the facility staff of his need for support and supervision. A review of Resident #2's record showed that his last health assessment was completed on _____ and he was not identified as an elopement risk. Further review revealed no documentation that Resident #2 had been assessed for elopement risk after he eloped from the facility on _____, on _____ and again _____. A review of the facility's Elopement Policy revealed the following: "10. All residents will be assessed for elopement prior to admission to the facility. Current residents	{A 032}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 19 will be assessed monthly for risk of elopement." "11. All residents at risk of elopement shall be identified so staff can be alerted to their needs for support and supervision." Interview on _____ at 8:00 am with the Assistant Administrator, when asked if the facility had identified residents that were at risk of elopement he stated, "No, because we don't have any elopement risk residents." A review of the local police department case report showed that officers found Resident #2 in the street on _____ after responding to a call referring to an elderly male that appeared lost and thirsty. The police case report also showed that officers transported Resident #2 to the hospital emergency department after he told the officers that he did not want to return to the facility and wanted to kill himself. The police case report showed that a _____ form was completed. A review of hospital records revealed that Resident #2 was brought into the emergency department by the local police department on _____ carrying a bag of his belongings due to acute _____. Further review of the hospital record showed a Clinical Impression of, "_____ with Precipitating Factors of _____ -patient does not like his ALF and does not want to go _____ there." Interview on _____ at 3:20 pm with the Administrator, when asked what measures the facility implemented after Resident #2's had eloped on _____ and on _____ she stated, "We provided him with a bracelet." When asked about documentation regarding the bracelet the Administrator stated, "No, it was not documented."	{A 032}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	---

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 20 Interview on _____ at 3:20 pm with the Administrator, when asked what was done after Resident #2's third elopement incident on _____ the Administrator stated that Resident #2 had not eloped; she stated, "He was outside the facility saying that he was going to get his money when the police came by while doing their rounds and they picked him up." Further review of the local police department case report revealed that Resident #2 was found at a location that is 2.1 miles away from the facility. Uncorrected Class II	{A 032}		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) _____ CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of _____ (a) The facility must implement a _____ hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or _____ hygiene may include the use of _____-based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an _____ exposure to transmissible agents in _____, nonintact skin, and mucous _____ during the provision of personal services. Standard precautions include: _____	A 036		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 036	Continued From page 21 hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, review of records and interview the facility failed to provide services in a manner that reduces the risk of transmission of One facility staff member (Staff C) out of fourteen sampled staff failed to follow control procedures by not removing his gloves and washing his immediately after handling potentially contaminated materials. Findings: Observation on at 9:00 am showed Staff C carrying a cleaning mop, handling garbage containers, and performing other cleaning chores while wearing the same pair of gloves. Further observation showed that Staff C touched the doors and countertop in common areas of the facility without removing, changing gloves, or washing his A review of the facility's Control and Hygiene Program showed, "Fresh gloves will be used for each situation and for each person served." Interview on at 9:05 am when asked if he had received training in control procedures Staff C stated, "Yes, I have CORE	A 036			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 036	Continued From page 22 training, I am wearing gloves because I was touching the garbage cans." Class III	A 036			
A 052 SS=F	429.256(); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an ... syringe that is prefilled with the proper dosage by a pharmacist and an ... that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's ... or placing the dosage in another container and helping the resident by lifting the container to his or her ... (d) Applying ... medications. (e) Returning the medication container to proper storage.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 23 (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a _____, including removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (4) Assistance with self-administration of medication does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____, of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 052	Continued From page 24 (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self-administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 25 enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility. 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's _____ control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the correct procedures outlined by the state when assisting one resident (Resident #25) with self-administration of medications. The facility also failed to follow _____ control procedures. Findings including:	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 26 Observation on _____ at 07:55 AM showed Staff F (Medication Technician and Caretaker) was standing inside the medications storage area while one resident was standing at the entrance door to the medications' storage. Observed Staff F had gloves on, and the bin of the medications was on the table in front of her. Observed Staff F was pouring medications from different bottles. For each bottle, observed Staff F poured the medications onto her _____, then from her _____ she transferred the medications into a small cup that was sitting on the table. Observed some of the medications _____ on the table several times while Staff F was pouring the medications on her _____; observed Staff F then took the medications that _____ on the table each time and placed them into the small cup. Observed Staff F then handed the small cup with some water to the resident. Staff F did not read the medication label or name the medications to the resident. Staff F also did not follow the facility's _____ control policy and procedures when assisting with self-administration of medications. Review of Staff F's record showed that Staff F received an initial 4 contact hours in assistance with self-administration of medications training in _____. Staff F also received continued education 2 contact hours in assistance with self-administration of medications training in _____. On _____ at 08:03 AM, Staff F stated, "I had to tell the name of the medications to the residents? First time I heard that; been here for 18 years." Staff F then stated, "I'm not supposed to touch the medications? On the table (medications _____ on the table)? Oh! I see."	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 27 Class III	A 052		
{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 offered or administered and include: 1. The name of the resident and any known allergies 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 restraints, 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.	{A 054}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 28 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a daily medication observation record (MOR) for one out of 38 sampled residents (Resident #8) who receives assistance with self-administration of medications. Findings included: Review of the facility's MOR for the month of _____ showed that Resident #8 only had one medication (Amox-Clav 875-125 MG) listed on his MOR for the month of _____. On _____ at 09:10 AM, the assistant administrator stated that he could not find the rest of Resident #8's MOR for _____. He stated, "I thought I gave it to you. I gave you _____, I only find this (showing one sheet of paper)." Uncorrected Class III	{A 054}		
{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	{A 077}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 29 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: 1. Be at least _____; 2. If employed on or after _____, 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	{A 077}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 30 ... , 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 ... 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 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	{A 077}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 31 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 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 . Further review showed the facility hired a	{A 077}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 32 manager on On at 5:47 AM, the Manager arrived at the facility and stated that the Administrator would not come because she had surgery. The Manager further stated that he had been working in the facility for about a month. The Manager could not say precisely how many residents were in the facility and how many were in the hospital. Throughout the survey, the Manager could not provide accurate information. On at 6:16 AM, when asked what his job duties were, the Manager stated that he helped with the orders at the facility, called the hospitals, was responsible for the documentation and the records, checked on the residents, and ensured that the residents took their medication. 2) A review of the Incident Report System (AIRS), hospital records and local police report revealed that Resident #2 had eloped from the facility on and In an interview on at 6:13 AM, when asked if Resident #2 was considered an elopement risk, the Manager stated, "No, there is no one here that is an elopement risk. Mentally [Resident #2] is not well, so we don't allow him to go out by himself." Review of Resident #2's progress notes dated revealed that, "[Resident #2] was saying that he was planning to leave the facility to get his money When the staff talked to him, he got agitated. The physician was called, and he suggested that he be transferred to the hospital for a medication evaluation."	{A 077}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 33 A review of Resident #2's hospital record dated showed a "gentleman brought in by police under the _____ for acute _____ . Patient was found walking in the street with a trash bag full of his own belongings by police. When police told him they were going to be transporting him _____ to the nursing home, the patient stated that he wanted to kill himself with a gun." A review of a police report filed on _____ showed that at 4:43 PM, officers responded to a call of "an elderly male who appeared to be lost." Resident #2 was observed walking approximately 2.1 miles away from the location of the facility. When interviewed, the resident expressed that he was thirsty and was unable to provide information about himself. Resident #2 was then transferred to the hospital under a _____ after expressing to officers he wanted to commit _____ . Further review of Resident #2's progress notes showed no documentation of the resident _____ from the facility on _____ . During an interview on _____ at 3:35 PM, when asked about the elopement on _____ , the Administrator stated the resident had not eloped. When asked why she thought Resident #2 was transported to the hospital after being found on the street with a bag of his belongings, the Administrator stated, "It was from here that the police picked him up. He doesn't have any belongings. [Resident #2] was saying that he was leaving because he had to pick up his money. The police weren't called. They were doing rounds, and he was saying all the craziness, and they took him. He was outside the gate. We were trying to get him to come _____ inside."	{A 077}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 34 3) On _____ at 7:05 AM, the Manager stated that Resident #6 was hospitalized and returned to the facility on _____. He further stated that then, Resident #6 was transferred _____ to the hospital the same day because he was not following commands, looked _____ and was not taking his medications. Review of Resident #6's observation log dated _____ showed that Resident #6 returned from the hospital. Further review showed that Resident #6 was transferred _____ to the hospital on the same day, _____ because he was _____ and was not taking his prescribed medications. Review of facility's hospitalization log showed that Resident #6 was transferred to the hospital on _____ due to _____ and red _____ and returned to the facility on _____. Further review showed that Resident #6 was transferred _____ to the hospital on _____ due to _____. Review of Resident #6's hospital record showed that the resident was admitted on _____. According to the report, "patient with many _____ conditions was brought to emergency room for evaluation due to reported _____ with _____ and disorientation. This was reported by [facility] staff. The patient has a significant decline in his _____ and mental status over the last 7 to 10 days. The symptoms/episode began/occurred 7 days ago and became worse today." Further review of the hospital report showed that Resident #6 stated that he was out of medications since Friday [_____].	{A 077}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 35 Review of Resident #6's medication observation record (MOR) showed that Resident #6 did not take any of his medications from to On at 3:16 PM, the Administrator stated that Resident #6 was declining, and they wanted to change him from his [health plan and provider of health care] because they were disenrolling and enrolling him. The insurance was not able to fill the prescription and Resident #6's medications came in until the 5th []. The Administrator further stated that they were trying to deal with the pharmacy to get Resident #6's medications even if it was for one day. However, there was no documentation regarding communication between the facility and the pharmacy. 4) On at 5:08 AM, observation showed Staff M (caretaker) fumbling with multiple keys as he tried unsuccessfully to open the resident's doors on the second floor. Then, Staff K and Staff D (caretakers) assisted Staff M, but they were still unable to open the door of # . At 5:10 AM, further observation showed that three emergency exit doors on the second floor were locked and could not be opened. On at 5:15 AM, when the employees were asked if the facility had a master key to open the resident's doors in case of an emergency, Staff K stated, "No, there is no master key, it's just that there are many keys and [Staff M] is new." On at 5:25 AM, observation showed paint cans, tools, and other construction materials on the floor behind the fire exit door, blocking	{A 077}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 36 egress to the stairway. Further observation showed that a stepladder had been placed across the first-floor doorway of the stairwell, blocking egress from and entrance to the stairwell. On at 5:25 AM, Staff D stated that the exit doors of the second-floor center stairwell were locked because they were doing maintenance work. On at 6:05 AM, observation showed several roaches coming from the bathroom next to the medication storage room. Further observation showed several roaches going into a cracked door panel. On 2023 at 8:15 AM, observation showed roaches on the wall and on the shelf in the dining area. Further observation revealed fruit flies in the kitchen area and on top of the garbage cans in the first-floor hallway. On at 9:40 AM, when asked if the facility had a professional pest control service, the Manager stated: "They (referring to the pest control vendor) were supposed to come 2 weeks ago, but I don't know if they came. I was in the hospital because I had problems." On at 9:57 AM, when asked for the pest control service contract or any past invoices the Manager stated: "Oh! I don't know where the pest control invoices are. I can't find the pest control contract." 5) A review of the Agency for Health Care Administration records revealed that during a complaint investigation conducted from	{A 077}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 37 through, the facility was cited for 11 deficiencies. During the revisit from through, the facility had 9 uncorrected deficiencies plus 5 new deficiencies. Class II Uncorrected	{A 077}		
{A 079} SS=D	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.	{A 079}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 38 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 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.	{A 079}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 39 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 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	{A 079}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 40 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 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 record review and interview, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern.	{A 079}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 41 Findings included: Review of the facility staffing scheduled from to revealed that Staff N was schedule to work as direct care staff. A review of the background screening clearinghouse database showed that Staff N was no longer in the facility employee roster with end date On at 3:15 PM, during a telephone interview, the Administrator stated that Staff N was no longer working since Class III Uncorrected	{A 079}		
A 152 SS-I	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 152	Continued From page 42 less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable height to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be soiled. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a safe living environment free of hazards to its residents, ensuring that building structure components, systems and furnishings are maintained in good working order. The facility also failed to ensure that emergency exits were accessible to allow residents to escape in case of fire or another emergency. Findings: Observation on _____ at approximately 5:00 am showed two resident chairs on the second-floor landing that were in disrepair, showing worn out and stained coverings (Photographic evidence obtained)	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 152	Continued From page 43 Interview on _____ at approximately 7:50 am when asked about the condition of the second-floor chairs, the Assistant Administrator did not respond. Observation on _____ at approximately 5:08 am showed Staff M fumbling with multiple keys as he tried to open the resident's doors on the second floor. Further observation showed that Staff M was not able to open the doors and asked Staff K to help him. Observation on _____ at approximately 5:10 am showed Staff K and Staff D coming to the second floor to open the resident's doors. Further observation showed that the staff was unable to open the door of # _____. Interview on _____ at approximately 5:15 am when asked if the facility had a master key to open the resident's doors in case of an emergency Staff K stated, "No, there is no master key, it's just that there are many keys and Staff M is new." Observation on _____ at approximately 5:10 am showed that three emergency exit doors on the second floor were locked and could not be opened. Observation on _____ at approximately 5:10 am showed that there was a strong smell of _____ on the second-floor residents' bathroom. Further observation showed that the smell was noticeable from the hallway. Observation on _____ at approximately 5:25 am showed paint cans, tools, and other construction materials on the floor behind the fire	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 152	Continued From page 44 exit door, blocking egress to the stairway (Photographic evidence obtained) Further observation showed that a stepladder had been placed across the first-floor doorway of the stairwell, blocking egress from and entrance to the stairwell (Photographic evidence obtained) Interview at approximately 5:25 am Staff D stated that the exit doors of the second-floor center stairwell were locked because they were doing maintenance work. Observation on _____ at 6:05 AM, showed several roaches coming from the bathroom next to the medication storage room. Further observation showed several roaches going into a cracked door panel (Photographic evidence obtained) Observation on _____ 2023 at 8:15 am showed roaches on the wall and on the shelf in the dining area. Further observation revealed fruit flies in the kitchen area and on top of the garbage cans in the first-floor hallway. Interview on _____ at 9:40 AM, when asked if the facility had a professional pest control service the Assistant Administrator stated: "They (referring to the pest control vendor) were supposed to come 2 weeks ago, but I don't know if they came. I was in the hospital because I had problems." Interview on _____ at 9:57 AM when asked for the pest control service contract or any past invoices the Assistant Administrator stated: "Oh! I don't know where the pest control invoices are. I can't find the pest control contract." A review of the facility's pest control policy reveals	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 152	Continued From page 45 "Establish and employ effective control to eliminate and contain roaches, fleas, rodents, etc." (Photographic evidence obtained) Observation on at approximately 5:15 am showed missing lamps and a nightstand drawer without a knob on . . . #. , no lamp on # and a strong smell of and feces in . . . #... Observation on at approximately 5:33 am showed an unpainted water leak repair on the first-floor ceiling, and a broken, delaminated closet door (Photographic evidence obtained) Interview on at 3:13 pm with the Administrator when told about the deficiencies the Administrator did not respond; she only stated that the facility had a telephone on the second floor. Class II	A 152		
{A 162} SS=E	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	{A 162}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 46 of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 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	{A 162}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 47 fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____, CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required 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	{A 162}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 48 participating in this arrangement. 2. The resident demographic data required in this paragraph. 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (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 maintain an accurate and complete health assessment for one out of 38 sampled residents (Resident #2). Findings include: A review of the facility's resident _____ and elopement risk log dated _____ showed Resident #2's risk assessment score of 9, indicating the resident was at risk to _____. A review of the agency's adverse incident	{A 162}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 49 database showed Resident #2 eloped from the facility on _____ and _____ A review of a police report filed on _____ showed that at 4:43 PM, officers responded to a call of "an elderly male who appeared to be lost." Resident #2 was observed walking approximately 2.1 miles away from the location of the facility. A review of Resident #2's health assessment (AHCA Form 1823) dated _____ showed a medical history and diagnoses of falling, _____ and _____. The resident was independent with ambulation, eating, toileting, and transferring and needed supervision with bathing, _____, and grooming. The health assessment indicated that the resident was not an elopement risk. A review of Resident #2's records showed no documentation of the resident being reassessed after the elopement attempts. Uncorrected Class III	{A 162}		
A 163 SS=D	429.49 FS Records - Resident, Penalties for Alteration (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges.	A 163		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	--

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 163	Continued From page 50 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that resident records were not falsified. Findings include: A review of progress notes dated _____ showed at 4:20 PM, "[Resident #2] was saying that he was planning to leave the facility to get his money _____. When the staff talked to him, he got agitated. The physician was called, and he suggested that he be transferred to the hospital for a medication evaluation." A review of Resident #2's hospital record dated _____ showed a "gentleman brought in by police under the _____ for acute _____. Patient was found walking in the street with a trash bag full of his own belongings by police. " During an interview on _____ at 3:35 PM, when asked why she thought Resident #2 was transported to the hospital after being found on the street with a bag of his belongings, the Administrator stated, "He doesn't have any belongings." A review of a police report filed on _____ showed that at 4:43 PM, officers responded to a call of "an elderly male who appeared to be lost." Resident #2 was observed walking approximately 2.1 miles away from the location of the facility. When interviewed, the resident expressed that he was thirsty and could not provide information about himself. Resident #2 was transferred to the hospital under a _____ after telling officers he wanted to commit _____.	A 163		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 163	Continued From page 51 During an interview on at 3:40 PM, when asked about the discrepancy of how Resident #2 was transported to the hospital, the Administrator stated, "[Resident #2] was saying that he was leaving because he had to pick up his money. The police weren't called. They were doing rounds, and he was saying all the craziness, and they took him. He was outside the gate. We were trying to get him to come inside." Class III	A 163		
(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	(A 165)		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 52 which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) _____, neglect, or _____ must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which	{A 165}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 53 case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to submit an adverse incident report with the Agency for Health Care Administration (AHCA) within one business day for one out of 38 sampled residents (Resident #2). Findings include: A review of progress notes dated showed at 4:20 PM, "[Resident #2] was saying that he was planning to leave the facility to get his money When the staff talked to him, he got	{A 165}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023	
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 54 agitated." A review of Resident #2's hospital record dated showed a "gentleman brought in by police under the for acute Patient was found walking in the street with a trash bag full of his own belongings by police. When police told him they were going to be transporting him to the nursing home, the patient stated that he wanted to kill himself with a gun." A review of the agency's adverse incident database showed no incident reports were filed for Resident #2's elopement. During an interview on at 3:35 PM, when asked why Resident #2's elopements were not reported, the Administrator stated, "It wasn't an elopement. The police weren't called. They were doing rounds, and he was saying all the craziness, and they took him. He was outside the gate. We were trying to get him to come inside." Uncorrected Class III	{A 165}			
A 167 SS=D	59A-36.018 FAC; 429.24 FS Resident Contracts 59A-36.018 Resident Contracts. (1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 55 extended congregate care services that the resident elects to receive; (b) The daily, weekly, or monthly rate; (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract; (d) A provision stating that at least 30 days written notice will be given before any rate increase; (e) Any rights, duties, or responsibilities of residents, other than those specified in section 429.28, F.S.; (f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments; (g) A refund policy that must conform to section 429.24(3), F.S.; (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or _____ facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf; (i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility; (j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 56 facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect; (k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule; (l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and, (m) The facility's policies and procedures related to a properly executed DH Form 1896, (2) The resident, or the resident's representative, must be provided with a copy of the executed contract. (3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 57 contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative. 429.24 FS (1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration. (2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and _____ of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period: (a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 58 located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident. (b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits. (3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or . . . (b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or , , facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee. (c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract. (4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility. (5) Neither the contract nor any provision thereof relieves any licensee of any requirement or	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/21/2023
NAME OF PROVIDER OR SUPPLIER CORAL SAND INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 59 ... imposed upon it by this part or rules adopted under this part. (6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055. (7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's or relocation due to hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have a contract executed by the resident's legal representative before or at the time of admission for one out of 38 sample residents (Resident #5). Findings include: A review of the facility's admission/ discharge log showed Resident #5 was admitted on	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/21/2023
---	--	--	---

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 167	Continued From page 60 A review of Resident #5's record showed the resident agreement was signed by the resident on Further review showed a court record dated, which documented that the resident was a ward of the Guardianship Program. The program was given guardianship of Resident #5's person and estate. In an interview on at 6:54 AM, when asked why Resident #5's contract was not signed by her guardian, Staff L, Assistant Administrator, stated, "The residents have a fiduciary. He doesn't sign it." In an interview with the caseworker from the Guardianship Program on at 3:42 PM, she stated, "The residents under the guardianship program cannot consent or sign any documents." Class III	A 167		