Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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 An unannounced Relicensure and Complaint survey, #2023011342, #2023012312, #2023015927, #2023017343, #2024000761, #2024009015 & #2024012910, and a Generator Monitoring survey were conducted on at Courtyard Gardens Of Jupiter. The facility had deficiencies related to the Relicensure survey and Complaint #2023017343 & #2024009015 identified at the time of the visit.	A 000		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation, interviews and record review, the facility failed to assist 1 out of 2 sampled residents (Resident #9) with activities of daily living (ADLs) as needed. The findings included: On at 10:00 AM, Resident #9 was observed being fed by Staff G in the secured unit dining room. On the same date at 12:45 PM, Resident #9 was observed in his wheelchair positioned in a diagonal angle facing his bed in his room. The resident stated "no" during interview at this time when asked if he wanted to go to the dining room to eat, but stated "yes" when asked if he was hungry. Staff G was observed entering the room and repositioning the resident at a small table facing the window in his	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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 028	Continued From page 1	A 028		

room, then obtaining a lunch tray from a transport cart to the table. The meal prepared by the dining room staff consisted of regular consistency stuffed shells, brussel sprouts and a piece of garlic toast. Staff G assisted the resident with the meal by cutting one piece at a time and feeding it to the resident. When asked if the resident was going to receive dessert since it was not included in the delivered meal, Staff G stated that the resident "doesn't usually want it".

During interview with the resident's representative on at 10:23 AM, the representative confirmed that the resident was to receive food as "mechanical soft", and stated that the resident is supposed to be eating in the secured unit dining room assisted by staff.

During review of Resident #9's record, the health assessment (AHCA Form 1823) dated singed by the health care provider noted that the resident was to receive assistance with meals and a " (mechanical soft) diet". This consistency requires food to be chopped, ground or pureed in addition to soft foods. Review of the resident's recordings revealed the resident's was , and the was .

Review of the facility's grievances on file revealed a written concern from the resident's representative dated that indicated the resident was having to be fed by the representative and "asks that we bring him (the resident) to memory care (secured unit) to assist with meals". This resolution was agreed upon by the facility in writing, with follow-up noted as "(resident) receiving staff assistance with meals". The resolution follow-up for this ADL assistance concern was discussed with the Administrator

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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 028	Continued From page 2 and Assistant Executive Director during interviews on at 3:00 PM. Class III	A 028		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). 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 that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure a staff member who has completed a course in First Aid in addition to being trained in , and holds a currently valid card documenting completion of such courses, was in the facility at all times during the night shift.	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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 083	Continued From page 3 The findings included: Review of the personnel file for Staff B who works as a caregiver during the 11:00 PM to 7:00 AM shift revealed no current training with a valid card in First Aid. During interview with the Assistant Executive Director on at 2:00 PM, documentation of a full time staff member on schedule working this shift who was trained in both and First was requested. There was no documentation of the training in both subjects for a full time staff member working the night shift available for review at this time. Class III	A 083		
A 170	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide a refund within 45 days of a resident's passing for 2 out of 3 sampled residents (Resident #15 and #16); and, failed to provide a prorated refund for a resident who was	A 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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 170	Continued From page 4 discharged from the facility for a higher level of care (Resident #2). The findings included: 1. On , Resident #15 , , and the representative subsequently moved the resident's belongings out of the facility on . A refund check of $9,950.34 was disbursed and picked up on the same date at the facility by the resident's representative on . A copy of this refund check shows the signature of a facility employee (Staff H) stating "received ", noting that the representative for the resident received the check on this date. In an email dated at 11:29 AM, the resident's representative confirmed that the person at the front desk who signed the photocopy of the check did so at his request on the day that he picked it up, as the check was expected within 45 days of the resident's passing. Review of the signature on this photocopy and a signed statement from Staff H indicating that she did not recall signing it matched, indicating that the date of receipt was accurate as documented. On , during review of the accounting of the resident's funds received by the facility and distributed to the resident, it was noted that no refund was due and that the resident had no balance as of . During interview with the facility's Business Office Manager on at 2:55 PM, she confirmed that there was no balance on the account and that no refund was provided to the resident's representative. She stated that a $980 balance was an "overpayment applied to a previous invoice". 2. On , Resident #16 , , and the representative subsequently returned the	A 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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 170	Continued From page 5 resident's room key on . A refund check of $8,973.40 was received by the resident's representative on . An email sent to the previous Administrator dated documents that the resident's room was cleaned and the key was returned, with hospice scheduled to pick up their equipment on . . On , during review of the accounting of the resident's funds received by the facility and distributed to the resident, it was noted that a refund was listed on as a "credit memo #1052-43724". During interview with the facility's Business Office Manager on at 2:55 PM, she confirmed that there was no balance on the account and that a refund was provided to the resident's representative by previous employees as she was not employed by the facility at that time. No other documentation was available for review to show the refund was disbursed and received within the required 45 day timeframe. Review of emails between the resident's representative and the facility representatives regarding the refund document the following: a. Previous Director Of Finance (DOF) writes on , "at this moment we won't be able to have the check ready. Checks are being submitted to the owner for signature this up coming week". b. Previous DOF writes on , "we expect the checks tomorrow". c. Previous DOF writes on , "the check arrived". d. The resident's representative responded, "Please go ahead and put it at the front desk...". 3. On , Resident #2 was sent to the hospital after sustaining a significant injury.	A 170		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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 170	Continued From page 6 During interview with the resident's representative on at 4:02 PM, she confirmed that the resident did not return to the facility after the incident as he required a higher level of care at a skilled nursing facility. She stated that she removed the resident's belongings by , and signed a termination of residency form at the facility's request on . She stated no refund was disbursed and the month of , was paid for in the amount of $6,200.00. The refund amount of $2,686.67 due to the representative was not provided as required for the prorated amount of the monthly charges since the resident's discharge and termination on for the time period of through . Chapter 429.24 (3), Florida Statute, requires that a refund policy "to be implemented at the time of a resident ' s transfer, discharge, or shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings...Except in the case of or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days ' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing	A 170		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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 170	Continued From page 7 of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident". The Administrator was notified of these findings on at 3:00 PM. The facility provided no additional information for review at the time of the survey. Class III	A 170		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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
CZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each	CZ875		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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
CZ875	Continued From page 1	CZ875		

employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information,

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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
CZ875	Continued From page 2 and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.	CZ875		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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
CZ875	Continued From page 3 (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , must complete the training required in this section before , . Proof of completion of equivalent training completed before , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 3 of 3 sampled direct care staff had completed the required / training within the regulatory time frames from the employees' date of hire (Staff A, Staff B, and Staff C). The findings included: Per review of facility documentation and the facility's web page, it was confirmed that this facility has a secured memory-care unit which offers specialized services to residents diagnosed with and related forms of .	CZ875		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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
CZ875	Continued From page 4 1) Per record review, Staff A is a Resident Assistant who provides direct care to residents. She was hired on . A thorough search of Staff A's employment record produced no documentation showing that Staff A received basic written information about interacting with persons who have or related forms of at the time of employment. There was also no documentation in Staff A's record which showed completion of the following required / trainings: 1 hour of / training within 30 days of hire ( ), an additional 3 hours of training within 3 months of hire ( ), and an additional 4 hours of -specific training within 6 months of hire ( ). 2) Per record review, Staff B is a Medication Technician who provides direct care to residents. She was hired on . A thorough search of Staff B's employment record produced no documentation showing that Staff B completed 4 hours of Level I 's/ training within 3 months of hire ( ), or an additional 4 hours of Level II training within 9 months of hire ( ). There was also no documentation that an annual 4 hours of continued education training was completed each year from 2022 through 2024. 3) Per record review, Staff C is a Medication Technician who provides direct care to residents. She was hired on . A thorough search of Staff C's employment record produced no documentation showing that Staff C received basic written information about interacting with persons who have or related forms of at the time of employment. There was also no documentation in Staff C's record which showed completion of the following	CZ875		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965339	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD GARDENS OF JUPITER	1790 INDIAN CREEK DRIVE WEST JUPITER, FL 33458

(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
CZ875	Continued From page 5 required / trainings: 1 hour of / training within 30 days of hire ( ), and an additional 3 hours of training within 3 months of hire ( ). On at 3:30 PM, the Administrator was informed of the missing training documentation for Staff A, Staff B, and Staff C. He was unable to provide additional training information to show compliance with training requirements. He stated that he would ensure all staff complete the 8 hours of approved 's/ training to ensure that all direct care staff are compliant with regulatory requirements. Class III	CZ875		