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
	AL11953535	A. BUILDING: _____ B. WING _____	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HOPE MANOR	2251 NW 29TH COURT OAKLAND PARK, FL 33311

(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 Generator Monitoring survey was conducted on at Good Hope Manor. Deficiencies were identified related to the Relicensure.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

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A 010	Continued From page 1 who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within	A 010		

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A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure that a resident was reassessed for continued residency upon exhibiting significant health changes and/or decline in health status for 1 of 13 sampled residents' records reviewed (Resident #1). This was evidenced by the facility's failure to document on the Resident Health Assessment (AHCA Form 1823) the participant's diagnoses (, , and marijuana addiction) and the , , service the resident was receiving (case management and , management). The findings included: Resident #1 was originally admitted to the facility on and re-admitted on Thursday , following a recent three (3) day hospitalization for "Acute ( ) and Acute , and Diastolic ( ) exacerbation with episodes of difficulty breathing. The resident's medical diagnoses as of included Atherosclerotic , Hypertensive and ( ) , Combined , and Diastolic ( ) with reduced ejection fraction, ( ), , ( ), Valve Replacement, Primary Generalized , , Attention and Concentration , Dependence (cigarettes), Long-term (current) use of , and Long-term (current) use of oral , , drugs. She had a Mental Status orientation to person, place and time x3, but with a disorientation to situation.	A 010		

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A 010	Continued From page 5 The resident's memory is described as: forgetful, misplaced objects with short-term loss. A review of Resident #1's file provided by the Nurse Liaison revealed a Health Assessment form (AHCA Form 1823) dated documented the medical history and diagnoses as , , , X 1, . There was no mention of , in her medical history. Additionally, it documented that Resident #1 was not receiving any nursing treatment or , services. Further review of Resident#1's file revealed hospital discharge paperwork dated with an admitting diagnosis of . Additional review of the hospital discharge paperwork revealed lab results dated that documented her level as 286mgDL (<100)-Fasting) [considered high]. During a tour of the facility on at 8:45 AM, Resident #1 was observed lying in bed with the slightly elevated. The resident had an uneaten breakfast meal (bagel and cream cheese) and beverage (hot tea) on the bench of her walker. Resident #1 was observed moaning in , while lying in bed. During an interview with Resident #1 on at 8:50 AM, she stated that she was always in , . She further stated that she's on , medication, but she still feels miserable. Resident #1 admitted to using marijuana in the past for her , and her , but she had "given it up". Resident #1 stated that she would smoke marijuana to put her in a euphoric . Resident #1 then stated she wanted to be out of her misery because she was tired of the , . When asked why she did not eat her breakfast meal, Resident #1 stated she did not have any	A 010		

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A 010	Continued From page 6 appetite due to how she was feeling. During an interview on at 9:55 AM with the Nurse Liaison, she stated that Resident #1 returned from the hospital last night ( ) after being admitted for 2 days for . She stated that Resident #1 was currently receiving services from a case manager and a , management doctor that come monthly. She further stated that the resident was admitted to the facility with , management services and she had been receiving them ever since. Furthermore, she stated that Resident #1 was previously using marijuana for , management and , symptoms, but the facility was a drug-free property. Additionally, she stated that Resident #1 had a marijuana addiction, and she had warned her that smoking marijuana would have negative effects with her , management medication. Furthermore, the Nurse Liaison stated that Resident #1 was considered for a 45-day eviction notice, but it was not given because the resident agreed to go on a rehabilitation program for about 1 week and has continued with day , . Per the Nurse Liaison, Resident #1 was on record as being "clean," since with no withdrawals. When asked why the addiction and , management were not identified on the resident's health assessment, the Administrator stated they have documentation of both in the resident file. Afterwards, the Administrator also stated Resident #1 is not a and did not have any orders to monitor levels. During an interview on at 1:21 PM with Resident #1's Management provider, she stated she had been working with Resident #1	A 010		

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A 010	Continued From page 7	A 010		

since , and for Low , and . She further stated Resident #1 was on , 10mg every 6 hours. The , management provider then stated that Resident #1 was in a substance rehab for recreational marijuana use (for , management). She further stated that she was not aware of where this resident would have gotten this "substance," from. Per the provider, Resident #1's , , valve conditions were manageable with the , management treatment if Resident #1 marijuana. However, testing Resident #1 for illicit substances tested positive for marijuana and the , management provider had to constantly educate her on the dangers of using marijuana while under the treatment. Additionally, the , management provider acknowledged that based on the medication profile, Resident #1 was and was taking two (2) different medications for this diagnosis.

During an interview with the Nurse Liaison and the Administrator on at 3:45 PM, they were informed that the documentation on file was not reflective of Resident #1's current behavior and diagnoses. Additionally, they were informed that the failure to document Resident #1's , and consistent of marijuana while on controlled substances for , management could place Resident #1 at risk of being ineligible for continued residency. Furthermore, they were informed that the failure to document the diagnoses (marijuana addiction, , , and) and the treatments (case management and , management services) on the Resident Health Assessment portrays an inaccurate idea of the care and services Resident #1 should be receiving. They acknowledged the findings.

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A 010	Continued From page 8 Class III	A 010		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the	A 031		

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A 031	Continued From page 9 facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on review of policy and procedure, observation, interview and record review, the facility failed to expeditiously communicate, coordinate and obtain a prompt physician ordered third (3rd) party provider re-assessment and re-evaluation, in order to re-initiate Home Health	A 031		

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A 031	Continued From page 10 care and services, for 1 of 1 sampled residents observed for a recent change in condition or status, Resident #1. The findings included: Review of the "un-dated" facility policy titled Third (3rd) Party Providers - Services Rendered provided by the Registered Nurse (RN) Liaison documented in the Policy Statement: It is the policy of this facility to adhere to the following procedures when allowing for 3rd Party Provider Services at this facility. A. Prior to approval for services any 3rd Party Provider MUST: ...2. Have a Physician's Order for providing services ....D. The 3rd Party Provider will be oriented by the Supervisor on Duty, regarding the medical condition of the residents who they will be providing services for .... Resident #1 was originally admitted to the facility on Tuesday and re-admitted on Thursday , following a recent three (3) day hospitalization for "Acute ( ) and Acute and Diastolic ( ) exacerbation with episodes of difficulty breathing. The resident's medical diagnoses included Atherosclerotic , Hypertensive and ( ) , Combined and Diastolic ( ) with reduced ejection fraction, ( ), , ( ), Valve Replacement, Primary Generalized , Attention and Concentration , Dependence (cigarettes), Long-term (current) use of and Long-term (current) use of oral drugs. She had a Mental Status orientation to	A 031		

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A 031	Continued From page 11 person, place and time x3, but with a disorientation to situation. The resident's memory is described as: forgetful, misplaces objects with short-term loss. During an observational tour of the facility's second floor on at 11:28 AM, this Surveyor knocked on the door and entered the room of "random," Resident #1. And, immediately upon entry, the resident was observed to be visibly , distressed, upset, moaning and holding her right lower side. The Surveyor then proceeded to briefly interview the resident to see how she was doing and ascertain if she had any complaints, concerns or issues with her care? The resident began by complaining of , in her right lower abdomen; which she stated has been on and off for about one (1) week. She said that it was not constant, but on a , scale of ; it was a . She added that she had not eaten anything today, up to this point. And, the resident also mentioned aloud that she stopped smoking cigarettes and some "other" inhalable substance about 3 weeks ago. Record review conducted of the Hospital lab results dated documented that the Resident #1 previously had a platelet count of 409 high (130-400 normal range), and a level of 286 high (<100 normal fasting), during her hospitalization indicative for prompt on-going monitoring, assessment and evaluation, of the resident. Further record review conducted of the Hospital Patient Hospital discharge instructions dated Thursday at 12 Noon revealed that one (1) of the follow-up instructions for this resident was with Home Health Services. Resident #1	A 031		

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A 031	Continued From page 12 medication list included the following fourteen (14) current medications which the resident was to keep taking at home: 24-26 mg ( ) one (1) tablet orally twice a day for ( ) ten (10) mg ( ) one (1) tablet daily an , six hundred (600) mg one (1) tablet orally every eight (8) hours as needed PRN for , ( ) 1,000 mcg one (1) tablet daily Supplement, (Jardiance) ten (10) mg one (1) tablet daily which works by helping the to remove sugar from the , which can lower the risk of and , forty (40) mg one (1) tablet daily used as a statin medication used to lower levels and reduce the risk of , and , eighty-one (81) mg one (1) tablet daily, ninety (90) mg ( ) one (1) tablet twice daily which works by preventing platelets from sticking together to form clots, which can , 0.63mg/3ml one (1) mg inhalation every four (4) to five (5) hours as needed used to treat or prevent , in individuals with and , ( ), , four (4) mg one (1) tablet orally twice daily , forty (40) mg one (1) tablet daily , Propanediol ten (10) mg ( ) one (1) tablet daily for and , twenty-five (25) mg one (1) tablet daily used to treat ( ) and , 5-325mg one (1) tablet orally every eight (8) hours as needed and 10 mg every six (6) hours around the clock for , according to her Management Doctor. Moreover, record review of the only two (2)	A 031		

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A 031	Continued From page 13 previous Home Health Certifications and Plans of Care (POC) dated to and to on file in the facility indicated that Resident #1 has multiple risk factors which include: history of , , , multiple emergency department visits in the past six (6) months, decline in mental, emotional, or behavioral status in the past three (3) months and reported or observed history of difficulty complying with any medical instructions involving medications, diet and exercise in the past three (3) months. The Home Health Agency (HHA) POC also documented that , the resident exhibits tremors, , agitation, irritability, , , judgement, impulsivity, poor coping skills, , , evasiveness, poor decision making ....resident tires easily, patient has a fast unsteady gait with a walker ....; there was no recent, subsequent HHA POC on file for this resident for SN and . Additionally, for the dates of to and to the HHA POC orders documented, "Skilled nursing (SN) and , , . SN ....to instruct patient on intervention (s) to monitor and mitigate , such as nonpharmacologic , relief measures, including relaxation techniques, massage, stretching, and re-positioning ....SN to report to physician if drug , , appears to be ineffective ...SN to instruct the patient/caregiver on precautions for high risk medications, such as , , , , , , ... , , ...Resident Goals and Outcomes .....Supervision to safely leave home, requires a considerable taxing effort due to , and difficulty walking, with minimum exertion, , vision/hearing, / , increased risk, forgetful/ , decision making, functional	A 031		

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	AL11953535	A. BUILDING: _____ B. WING _____	08/29/2025

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A 031	Continued From page 14 decline and due to recent exacerbation ( ) of , / / , and . Patient gets easily agitated and demanding and has poor insight and judgement into her behaviors and is unsafe to leave home unattended. SN to provide skilled observation and assessment of vital signs, all body system, assess mental and physical status, assess for compliance and instruct on actions, side effects, and effectiveness of prescribed medications, diet and nutritional status, and patient/caregiver's knowledge of signs/symptoms of complications, process and precautions, instruct as needed; assess home for safety to prevent ....SN to instruct patient/caregiver on signs and symptoms of complications and when to call 911. SN to instruct patient/caregiver on signs and symptoms of , risk factors, complications and preventative care or management measures including diet and prescribed medications. SN to instruct patient/caregiver on signs and symptoms of such as: , ( ) which is generally triggered by physical or emotional stress, ( ), . SN to instruct patient/caregiver on signs and symptoms of to include crushing pressure in your and , in your or arm, sometimes with and sweating. Instruct to call 911 if signs or symptoms of . SN to instruct patient/caregiver on signs and symptoms of management and lifestyle changes such as: ( ) control, quit smoking, manage stress, eat healthy foods, medication compliance, exercise, maintain a healthy . SN to assess for changes in status every visit ...." An interview was conducted with the RN, Nurse Liaison, on at 11:43 AM regarding the resident's complaint of . She stated that	A 031		

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A 031	Continued From page 15 Resident #1 was receiving , management in the facility, for , . Prior to this, she said that the resident had been going to a management clinic located outside of the facility. The RN Nurse Liaison acknowledged that the , complaint and lack of appetite were both "new." The RN Nurse Liaison also acknowledged that Resident #1 had stopped smoking cigarettes and some "other" inhalable substance about three (3) weeks ago, and she added that's why the resident was used to doing this was because she liked the "Euphoria," it gave and because she would get "Depressed." The Nurse Liaison also went on to say that Resident #1 had previously been receiving skilled home health services in the facility from to and again from to She also acknowledged that these services were to continue after the resident's re-admission to the facility following her recent hospitalization. However, the Nurse Liaison revealed that these skilled services for her change in condition had still not yet been resumed for the resident, prior to the end of this survey. However, at that time, the Nurse Liaison, had not indicated whether or not the HHA had been contacted yet, in order for the resident to resume receipt of her HHA care and services following Resident #1's very recent re-admission to the facility on , to ensure continued appropriate placement, for this resident An interview was conducted with Staff I, Home Health Aide (HHA) on at 3:11 PM in which she revealed that the resident refused and did not want any breakfast this morning, but she said that the resident did request some iced tea with milk and sugar for which she had that twice today (once earlier). The HHA stated that she	A 031		

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A 031	Continued From page 16 also took a bagel into the resident's room, for which the resident did not eat, at any point today. The HHA further stated that for lunch this afternoon, the resident refused lunch, which had been taken into her, but nothing else because she said that the resident had , and she still refused to eat, for which she said that the medication technician was aware. The HHA added that the resident usually eats her food. The HHA ended by saying that the resident told her that she had felt a little "down," today. On the "un-timed," Physician's Order documented, "Home Health to evaluate and treat , , {)/Skilled Nursing (SN) Diagnosis: /Unsteady gait. During a side-by-side resident record review conducted with the Nurse Liaison, it was revealed that there was no direct documented evidence reviewed, nor provided by the facility to show that a current physician's order had been obtained prior. And, neither was there any evidence to show that the Home Health Agency had been contacted, prior to the survey entry date nor that the HHA visited the facility prior to the exit date of this survey, in order for Home Health services to have been re-initiated for skilled nursing care, for this resident, until after surveyor intervention. The Nurse Liaison, further recognized and acknowledged on at 11:51 AM that the resident should have been re-assessed and re-evaluated to ensure prompt receipt of ordered HHA care and services. Class III	A 031		

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A 152	Continued From page 17	A 152		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate 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	A 152		

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A 152	Continued From page 18 be . This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all existing appurtenances are maintained in good working order. The findings include: Observation on at 2:33 PM, showed the dinning room consisted of 44 black plastic foldable chairs, and 5 wooden chairs. Out of 44 black plastic foldable chairs, 38 were in ripped conditions with the stuffing being exposed. Interviewed on at 12:20 PM Resident #16, in stated, she likes the wooden chairs better, that's why she is sitting on one. Interviewed on at 12:30 PM Resident #15, from stated the chairs uncomfortable, specially when she is wearing shorts. Interviewed on at 12:40 PM Resident #17, from stated the chairs are not good, she stated she has been living here for years, and "the chairs have been ripped since forever ago". Interviewed on at 12:45 PM Resident #18 from stated the chairs need to be changed due to them being uncomfortable, and the facility should put all wooden chairs. Interviewed on at 2:43 PM, The Administrator stated she is aware of the conditions of the chairs in the dinning room, and stated she is hoping within 90 days to replace	A 152		

Agency for Health Care Administration

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A 152	Continued From page 19 them. The administrator Stated, about 2 months ago she inspected the facility regarding physical plant, and that was on the to-do list. Class III	A 152		