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
	AL11942866	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

(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 complaint investigation for #2025017619 and an emergency power plan monitoring survey was conducted at Courtyard Assisted Living (the) on . Deficiencies was identified at the time of the survey.	A 000		
A 152 SS=D	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	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942866	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

(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 1 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 . . This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to maintain a clean, and decent living environment free from foul odors for 3 resident rooms (#132, #133, #139) of 37 resident rooms toured. Observations on from 9:03 a.m. to 9:30 a.m.revealed the following: A very strong odor of in # , # , # . The foul odor of was prominent on the hallway toward # . # . On at 9:30 a.m., during an interview Staff A said Resident #1 who occupied # would urinate on the floor, and liked sleeping with soiled clothes on his bed, resulting in the foul odor emanating from the room. Furthermore, the resident who occupied # tended to refuse showers and refused staff changing his briefs. Staff A said all rooms were to be cleaned weekly but, # was on a daily cleaning rotation because of Resident #1's tendency to urinate on the floor, and they have only one housekeeper for the whole building. Staff A said she spoke to the Administrator/owner because she thought they	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942866	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

(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 2 needed additional housekeepers, but he refused to hire more housekeepers. Staff A said she told the Administrator to address the issue, but nothing was done. Staff A said that # also was on a daily cleaning rotation since Resident #2 who occupied the room was and she believed that because he had so many episodes the tiles on the floor absorbed the odor and regardless how much they clean the room still smelled. Staff A said # is occupied by Resident #3 who is also and she does not like to change her clothes after an episode. During an interview with Staff B on at 9:45 a.m. she said Resident #1 refused to shower, and he liked staying in bed with soiled clothes, and liked to urinate on the floor. They have him on a daily cleaning schedule, but they can't keep up since he continues to urinate on the floor and refuses to get changed or shower. Staff B said they told the Administrator, but he does not want to address the issue. Resident #2 in # is also and he is also on a daily cleaning schedule, but she believes the tiles have been saturated underneath from accumulation of and that is why the room smells. Resident #3 in # usually does not smell. Staff B said maybe Resident #3 had an accident. Record review of the facility shower log showed Resident #1 refused to take showers with last shower documented taken on and refusals since then. During an attempt to interview Resident #1 on at 11:00 a.m. he stated " to mind your own business, and leave my room". During an interview, Resident #2 on at	A 152		

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
	AL11942866	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

(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 3 11:13 a.m. he said he does not smell anything. During an interview, Resident #3 said on at 11:20 p.m. that her room smell nice. On at 12:30 p.m., during an interview Staff C Housekeeper said all rooms were to be cleaned weekly. # , # , # were on rotation weekly. Staff C said # was the main issue because Resident #1 liked to urinate on the floor, refused to change his soiled clothes, and refused to take showers. Staff C said she believes that even though they clean daily and change his linens daily, the mattress was saturated with resulting in the foul odor regardless of how much it was cleaned. Staff C said # was a similar situation and was on daily cleaning due to Resident #2 being and the tiles in the room most probably were saturated with creating the foul odor. # was on weekly rotation and usually did not smell. She believed that most probably the Resident #3 had an accident and did not change her clothes. On at 2:00 p.m., during an interview the Administrator confirmed there was foul odors of in # , # , # . The Administrator said the staff never notified him of the foul odor and he did not smell it him self. Class III	A 152		