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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 Assisted Living Facility biennial relicensure survey with Extended Congregate Care (ECC) was conducted on through . Grand Court Village II, had licensure deficiencies found at the time of the visit. Note: A complaint inspection survey (CCR #2013002207) was conducted in conjunction with the biennial licensure survey. Please refer to the separate report.	A 000		
A 010 SS=D	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a stage sore be retained provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident	A 010		

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 010	Continued From page 1	A 010		

contracts directly with a licensed home health agency or a nurse to provide care;
2. The condition is documented in the resident ' s record; and
3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall 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 the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed;
2. Continued residency is agreeable to the resident and the facility;
3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and
4. Documentation of the requirements of this paragraph is maintained in the resident ' s file.
(d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.
(e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
(5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.

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
	AL11942933	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 010	Continued From page 2	A 010		

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure the 1823 Health Assessment was updated after significant changes in condition for 2 out of 16 resident charts reviewed (Resident #7 and Resident #9). As evidenced by the 1823 Health Assessment not reflecting Residents #7 and #9's current condition.

The findings include:

1) Resident #7 was admitted to the facility on [redacted] to include alzheimers, dementia, [redacted]

On [redacted] :35 a.m., Resident #7 was observed in the main activity room reclining [redacted] geri chair with a lap tray in place. An Aide was observed to assist the resident with drinking juice by holding the glass for the resident. An attempt was made to communicate with the resident. However he was nonverbal with a distant affect.

On [redacted] :28 p.m. Resident #7 was observed during the dining observation to remain in the geri chair with lap tray. The Director of Nurses (DON) was observed to be feeding the resident. Resident #7 made no effort to attempt to feed himself and was totally dependent on assistance.

On [redacted] 10 a.m. Resident #7 was observed in the main activity room reclining [redacted] geri chair with a lap tray in place. The resident

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 010	Continued From page 3	A 010		

remained nonverbal when spoken to.

Review of the Resident #7's record revealed an 1823 Health Assessment dated The assessment documented the resident had periods of forgetfulness, was ambulatory with a walker, required supervision with ambulation and transferring and was independent with eating.

On at 2:48 p.m. an interview was conducted with the Administrator, who stated the 1823 Health Assessment is good for 3 years. It was pointed out that on the resident was independent with eating and required supervision with ambulation and transferring. However, the resident is now confined to a geri chair and requires total assist with eating. The Administrator concurred there has been a change in Resident #7's condition and a new 1823 Health Assessment should be done to reflect the changes.

2) Resident #9 was admitted to the facility on with diagnoses to include and

On at 10:00 a.m. an interview was conducted with the Administrator who stated they currently do not have any residents under ECC (extended congregate care). Review of the ECC log revealed the last resident that was under ECC was in 2009.

On at 10:45 a.m. Resident #9 was observed in the main activity in a geri chair. The resident was nonverbal and unable to make her needs known. At 10:50 a.m. Resident #9 was observed to be fed juice and cookies by the Aide. Resident #9 made no attempts to assist with eating or repositioning in

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 010	Continued From page 4 the geri chair and required the assistance of 2 people to reposition her in the geri chair prior to assisting with eating and drinking. At 12:30 p.m. Resident #9 was observed in the dining . . . . the geri chair receiving total assistance for feeding by an aide. The resident remained nonverbal and made no attempts to assist with eating or communicate in any way. On . . . . at 9:15 a.m., Resident #9 was observed in the main activity . . . the geri chair. The resident remained nonverbal and was observed to be slouching down the geri chair and she made no attempts to reposition herself and required the assistance of 2 people to reposition her higher up in the chair. Review of Resident #9's record revealed a Health Assessment dated . . The assessment documented the resident as being awake, alert and oriented x 1, required assistance with transfer and required assistance with ambulation, eating and activities of daily living. Additionally, the assessment documented the resident was on hospice. Further review of the resident's chart revealed no evidence of documentation that she was currently under hospice care or at what point since 2011 the resident required the use of a geri chair for mobility or positioning. On 04/1 . . . 11:15 a.m., an interview was conducted with the DON who stated resident #9 was on hospice but was taken off. However, she was not sure at what point the hospice was terminated. It was noted in the resident's record a urinalysis was ordered on 03/0 . . . Resident #9. However, there were no lab results in the chart. A further inquiry was made to the DON what the results of the urinalysis were and after reviewing the resident's record and looking through papers that still needed to be filed into	A 010		

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 010	Continued From page 5 resident charts, the DON stated it looks like it was not done probably because Resident #9's lower extremities are very contracted and it is difficult to get her legs apart. Further review of the resident's record revealed no evidence of documentation at what point the resident became contracted and totally dependent for activities of daily living and ambulation and positioning. On at 11:30 a.m. an interview was conducted with the Administrator and DON, who stated they were not aware a resident could not be in a geri chair if they were not under hospice. An inquiry was made why Resident #9 was not under ECC taking into account her current physical and status and the Administrator and DON were unable to provide an answer. class III	A 010		
A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care	A 025		

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 6 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure resident records accurately reflected their conditions for 3 out of 16 sampled residents (Residents #7, #8 and #9). As evidenced by the facility failing to document the assessment and condition of Resident #7's head [illegible] after a [illegible]; failure to assess and document a scalp [illegible] for Resident #8; and failure to follow up with the status of a laboratory test for Resident #9. The findings include: 1) Resident #7 was admitted to the facility on [illegible] with diagnoses to include [illegible] and [illegible]. The resident is currently under hospice care. On [illegible] at 10:35 a.m. resident #7 was observed in the main activity [illegible] in a geri chair with a lap tray secured to the geri chair. Further observation revealed he had a [illegible] caked [illegible] to the temple area, left of his left	A 025		

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 7	A 025		

eye which appeared to have black stitches poking through the caked [illegible] and a large yellowish purple [illegible] from his left forehead area to below his left cheek. The resident is [illegible] and nonverbal and unable to answer questions or make his needs known.

Review of the Resident #7's record revealed Observation Notes dated [illegible] stating "While in lobby resident knocked off tray to geri chair and [illegible] to the floor. He has a split on his face near the left eyebrow. I called hospice because I feel it may need stitches, they informed me to send him to the hospital and he went 911. The [illegible] was approximately at 6:50 a.m. and he left facility via ambulance at 7:15 a.m."

Review of a Nurse's Note dated [illegible] documents "Reported to this nurse that this resident had [illegible] out of his geri chair and had been sent to hospital for evaluation and treat."

Further review of the resident's record revealed no evidence of documentation when the resident returned to the facility or any assessment or monitoring of the condition of his injuries upon return to the facility or thereafter. Additionally, there is no evidence of documentation the resident's next of kin were notified of the [illegible] and subsequent injuries.

On [illegible] at 3:00 p.m. an interview was conducted with the Director of Nurses (DON) who stated the resident is seen by the hospice nurse 3 times a week and they are the ones that are assessing the resident's injuries. She stated after the incident the resident was placed on crisis care and was seen by the hospice nurse 24/7. She further stated crisis care was discontinued on [illegible] and the resident was seen by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 8	A 025		

hospice nurse and doctor yesterday on . An inquiry was made to the DON who was monitoring or assessing the resident's condition and stitches to his face after hospice crisis care was discontinued on up to today, , and she stated she discussed the stitches with the hospice doctor yesterday. Review of the resident's record and the hospice chart revealed no evidence of documentation or follow up regarding the resident's condition or care or assessment of the stitches to the temple area on the left side of his face.

On at 4:00 p.m. the DON made a clarification that the resident did not have stitches but had steristrips over the laceration. There remained no evidence of documentation whether the resident had stitches or steristrips to the laceration to the temple area of the left side of his face.

On at 9:15 a.m., Resident #7 was observed in the main activity in the geri chair with the lap tray secured to the geri chair. Observation was made of the laceration to the resident's left temple area which remained caked with dried and which continued to look like black stitches poking through the caked . Steristrips were not observed on the laceration.

2) Resident #8 was admitted to the facility on with diagnoses to include accident and .

On 45 a.m. in the main activity room resident observed to have an open wound to top of his scalp. An inquiry was made to the aide present what the wound was how he got it and she stated the resident

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 9 picks at his scalp all the time and if they put a dressing on it he will take it off right away. Review of the Resident #8's record revealed a physician order dated . . . . . for a home health consult for . . . . . care to scalp with a diagnosis of scalp . . . . . Review of nurses notes prior to . . . . . , revealed no evidence of documentation regarding the scalp . . . . . , how the resident obtained the . . . . . and no documentation the family was notified of the scalp . . . . . . Review of the Observation Notes dated . . . . . documents 'Resident seen by MD, orders for home health care consult for wounds to scalp.' Review of the Nurse's Notes dated . . . . . states "This resident was seen by physician yesterday. No changes to the plan of care." There is no documentation regarding the assessment or monitoring of the scalp . . . . . Further review of the resident's record revealed a physician order dated . . . . . for . . . . . cream to scalp twice daily until healed. Review of the facility Nurse's Notes and Observation Notes revealed no entries for the months of . . . . . 2012 through . . . . . 2013 regarding the assessment or monitoring of the scalp . . . . . . Review of a home health skilled nursing (SN) note dated . . . . . documents the . . . . . care being rendered by the SN stating the . . . . . is healing with the expectation the resident will be discharged from their services on . . . . . Further review of the home health Skilled Nursing notes documents the resident was discharged from their services on . . . . . with the	A 025		

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 10	A 025		

healed.

Review of the Observation Notes dated [redacted] states 'Resident seen by [redacted] New order for [redacted] cream to scalp twice a day until healed.' There is no further documentation regarding the condition or assessment of the scalp [redacted]

Review of the [redacted] Medication Observation Record (MOR) for [redacted] documents the [redacted] cream apply to scalp twice a day until healed dated [redacted] with a hand written notation 'Home Health'.

Review of the resident's record revealed a physician order dated [redacted] to 'Discontinue [redacted] care with [redacted] due to chronic condition.' Further review of the resident's record revealed no description or assessment of the scalp condition.

Review of the [redacted] MORs documents the [redacted] cream apply to scalp twice a day until healed with a hand written notation 'Per Home Health', however the cream was discontinued on

On [redacted] at 12:25 p.m., an interview was conducted with the home health nurse in the presence of the DON, who stated the resident is no longer on their service and they would not provide twice a day services to apply the [redacted] cream because it is not a skilled service and Medicare would not pay for it.

On [redacted] at 12:40 p.m. an interview was conducted with the DON, who stated she did not document anything about the scalp [redacted] because it is a chronic thing and if they put a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 11	A 025		

dressing on it he would take it off right away as he is constantly scratching his head. The DON concurred that there was no baseline assessment of the condition to determine, if it was getting worse or better.

3) Resident #9 was admitted to the facility on 11/2 [illegible] diagnoses to include alzheimers, [illegible] osteoarthritis.

[illegible] of the resident's record revealed a physician order dated 03/0 [illegible] a urinalysis and urine [illegible] for a diagnosis to rule out a urinary [illegible] directions the urine [illegible] be obtained via a straight catheterization.

[illegible] of the resident's record revealed a Nurse's Note stating "New orders received via fax for this patient to have a urinalysis for culture to rule out UTI. [illegible] given to home health nurse."

Further review of the resident's record revealed no results of the urinalysis that was ordered on 03/0.

[illegible] 04/1 [illegible] 11:15 a.m. an interview was conducted with the DON, who was unable to find the results in the chart or in loose papers to be filed. She stated it was the home health nurse that was to obtain the urine [illegible] and it looks like it has not been done yet. An inquiry was made who is responsible for following up with physician orders to see if they have been carried out by the home health and the DON stated she is responsible for follow up of labs and she was not aware it was not done yet. Additionally, she stated the resident is very contracted and it is difficult to get her legs apart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 12 On 04/1 : 11:26 a.m., an interview was conducted with the home health nurse in the presence of the DON who stated she has attempted to get the urine : 3 times and has informed the physician. However, the DON was not aware the sample was not yet obtained to rule out a UTI. . . . stated the resident is very contracted and it is difficult to pry her legs apart without discomfort but she will try again today. Review of the home health Skilled Nursing notes documents an attempt to obtain the urine was on 03/0 : 03/1 : of the resident's record revealed no communication between the facility and the home health agency regarding the status of the resident and inability to obtain the urine On 04/1 : 12:15 p.m. the DON stated the home health nurse just obtained the urine for resident #9 (5 weeks after the physician order to rule out a UTI) : the lab has been called to pick up the specimen. class III	A 025		
A 030 SS=D	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) 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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident	A 030		

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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	A 030		

complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 (g) The facility shall 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 shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical 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.	A 030		

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
	AL11942933	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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	A 030		

(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve 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 [illegible] 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) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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	A 030		

case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the 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.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure residents were free from for 1 out of 16 sampled residents (Resident #7). As evidenced by resident #7 having a lap tray secured to his geri chair.

The findings include:

Resident #7 was admitted to the facility on with diagnoses to include , and . Resident #7 is currently under the services of hospice care.

On at 10:35 a.m. Resident #7 was

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 17	A 030		

observed in the main activity in a geri chair with a lap tray secured to the geri chair. An Aide was observed to assist the resident with drinking juice by holding the glass for the resident. An attempt was made to communicate with the resident. However, he was nonverbal with a distant affect. The resident was not observed to be restless or independently moving his limbs. An aide was observed to be in the activity the residents.

On at 12:28 p.m., Resident #7 was observed during the lunch dining observation to remain in the geri chair with the lap tray secured to the geri chair. The Director of Nurses (DON) was observed to be feeding the resident. Resident #7 made no effort to attempt to feed himself and was totally dependent on assistance. The resident was observed to be calm and quiet.

On at 2:30 p.m., Resident #7 was observed in the main activity front of the television reclining in a geri chair with the lap tray secured to the geri chair. The resident was not observed to be restless or independently moving his limbs. An aide was observed to be in the activity the residents.

On at 3:20 p.m. an interview was conducted with the Administrator and DON regarding the use of a lap tray as a device. The Administrator and DON, stated they were under the impression that if a resident was on hospice it was alright to have a lap tray. Review of the resident's record revealed no evidence of documentation when the lap tray was initiated.

Further review of the resident's record revealed Observation Notes dated stating "While

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 18 in lobby resident knocked off tray to geri chair and [redacted] to the floor. He has a split on his face near the left eyebrow. I called hospice because I feel it may need stitches, they informed me to send him to the hospital and he went 911. The [redacted] was approximately at 6:50 a.m. and he left facility via ambulance at 7:15 a.m." The time of the [redacted] at 6:50 a.m. indicates the lap tray was placed when the resident was taken out of bed for the day. Review of the incident report dated [redacted] states under steps taken to prevent recurrence, "Staff instructed to make sure tray is in proper place and secured tightly to prevent removal by resident." On [redacted] at 9:10 a.m. Resident #7 was observed in the main activity [redacted] in a geri chair and continued to have the lap tray secured to the geri chair. The resident remained nonverbal when spoken to, calm and quiet. An Aide was observed to be in the activity [redacted] the residents. class III	A 030		
A 092 SS=D	58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic	A 092		

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 092	Continued From page 19	A 092		

diets as ordered by the resident ' s health care provider for resident ' s who require special diets.
(d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C.

This Statute or Rule is not met as evidenced by:
Based upon observation record review and interviews, it was determined that the facility failed to ensure that food services were provided in a safe and sanitary manner.

The findings include:

1. Tour of the kitchen was conducted on at 11:10 AM revealed the following.

a) 5 frying pans were observed to be and extremely blackened both inside and out
b) 14 Dishwashing trays were observed to be excessively worn and in very poor condition.
c) 4 kitchen vents were observed to be excessively dirty and in need of cleaning.
d) window to the kitchen was observed to be open; the screen was observed to be torn and loose.
e) The sanitizing bucket used to clean the food prep area was observed to have an exceptional amount of sanitizer when tested. The test strip was observed to become black when placed in the water rather than light purple. An interview with the cook was conducted on at approximately 11:28 AM, during which he agreed that there was too much sanitizer placed in the bucket
f)Several loaves of bread was observed in the freezer to be unfrozen. A review of the

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 092	Continued From page 20 temperature gauge on the freezer revealed the gauge was cloudy and brown on the interior and a correct temperature reading could not be obtained. The cook was unable to tell if the freezer was functioning properly as there was no explanation as to the bread being unfrozen in the freezer for over a week g) 39 loaves of bread found in the freezer was observed to be expired with dates ranging from [redacted] through [redacted]. The bread packaging was observed to not have a freeze by date indicated on the packaging and the bread was observed to be unfrozen. Class III	A 092		
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, [redacted] and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows:	A 093		

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 093	Continued From page 21	A 093		

1. Protein: 6 ounces or 2 or more servings;
2. Vegetables: 3 5 servings;
3. Fruit: 2 4 or more servings;
4. Bread and starches: 6 11 or more servings;
5. Milk or milk equivalent: 2 servings;
6. Fats, oils, and sweets: use sparingly; and
7. Water.

(c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.

(d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months.

(e) Therapeutic diets shall be prepared and served as ordered by the health care provider.

1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 093	Continued From page 22	A 093		

document what is eaten unless a health care provider ' s order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility.
2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary.
(f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand.
(h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 093	Continued From page 23	A 093		

canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.

This Statute or Rule is not met as evidenced by:
Based on observations, record review and interview, it was determined the facility failed to comply with dietary standards.

The findings include:

1. Observation of the lunch meal conducted on [redacted] at 12:00 PM revealed :
a) no standardized recipes were being utilized for meal preparation. An interview was conducted with the cook who stated he used his own recipes to comply with the menu items.
b) The lunch trayline was observed to be plated by the chef and revealed portion sizes were not being followed as specified on the menu. An interview was conducted with the cook who stated that there are no proper serving utensils available and no scale available with which to measure menu items.
c) observation of the desert tray for the secured unit revealed tapioca was served to the residents in disposable styrofoam bowls. An interview with the cook revealed that the facility did not have sufficient bowls with which to serve the residents.
d) Record review was completed on [redacted]

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 093	Continued From page 24 and revealed the facility did not have on file the required six months regular and therapeutic menus available for inspection. e) Observation of the snack items served to resident in the secured unit on [redacted] at approximately 2:10 PM was observed to be served to the residents on paper napkins. An interview was conducted with the dietary aide on [redacted] who stated the residents normally break the plates due to their [redacted] status and therefore are not served snacks on a small plate. f) Temperatures taken of the items for the lunch meal on [redacted] revealed the temperature of items on the tray line to be: I.)Chicken 130 degrees II.)Greens 110 degrees III.)Maccaroni and Cheese 110 degrees Temperatures for items served in the secured unit on [redacted] revealed the food temperatures were below 110 degrees for the items on the trays for both regular and pureed meals which is not consistent with safe food handling practices (unable to ensure palatable).	A 093		
A 152 SS=D	58A-5.023(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.; and 2. Must be maintained free of hazards; and 3. Must 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 shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident [redacted]	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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 25	A 152		

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 a comfortable height to ensure easy access by the resident;
2. A closet or wardrobe space for hanging clothes;
3. A dresser, chest or other furniture designed for storage of personal effects;
4. A table, 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 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 shall be free of tears, stains and not be

This Statute or Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to provide a safe living environment.
The findingsinclude:
1. On , 2013 between 12:00 PM and 1:00 PM, surveyor observed the luncheon meal being served in the Dining serving the secure unit residents. Sixteen residents were present for the Luncheon meal. During this period surveyor observed a hundred or more black worms moving about on the floor between the dining The worms were 2 to 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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 26 inches long and completely black in color. During an interview with the Administrator at approximately 3:30pm on , she said it must have been the recent rains. 2. On , 2013 at approximately 10:10 AM, surveyor was touring facility and talking to randomly selected residents. In , the was found to be heavily stained and in need of maintenance. 3. During a tour of the facility from approximately 9:50 to 10:30 AM, surveyor found many maintenance concerns with the main corridor carpeting. In many places the carpeting was stained and had a bleached appearance, in many other locations the carpeting had been cut and patched with the cuts and patching places showing badly as a result of poor workmanship. In many other locations the carpeting was badly worn and needed replacement. class III	A 152		
AE207 SS=D	58A-5.030(8) FAC ECC - Services (8) EXTENDED CONGREGATE CARE SERVICES. All services shall be provided in the least restrictive environment, and in a manner which respects the resident ' s independence, privacy, and dignity. (a) An extended congregate care program may provide supportive services including social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self directed activities, and volunteer services. Family or friends shall be encouraged to provide supportive services for residents. The facility shall provide training for family or friends to enable them to provide	AE207		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942933	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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
AE207	Continued From page 27	AE207		

supportive services in accordance with the resident ' s service plan.
(b) An extended congregate care program shall make available the following additional services if required by the resident ' s service plan:
1. Total help with bathing, dressing, grooming toileting;
2. Nursing assessments conducted more frequently than monthly;
3. Measurement and recording of basic vital functions and weight;
4. Dietary management including provision of special diets, monitoring nutrition, and observing the resident ' s food and fluid intake and output;
5. Assistance with self-administered medications, or the administration of medications and treatments pursuant to a health care provider ' s order. If the individual needs assistance with self-administration the facility must inform the resident of the qualifications of staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident ' s or the resident ' s surrogate, guardian, or attorney-in-fact ' s informed consent to provide such assistance as required under Section 429.256, F.S.;
6. Supervision of residents with dementia cognitive
Health education and counseling and the implementation of health-promoting programs and preventive regimes;
8. Provision or arrangement for rehabilitative services; and
9. Provision of escort services to health related appointments.
(c) Licensed nursing staff in an extended congregate care program may provide any nursing service permitted within the scope of their license consistent with the residency requirements of this rule and the facility ' s written

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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
AE207	Continued From page 28	AE207		

policies and procedures, and the nursing services are:
1. Authorized by a health care provider ' s order and pursuant to a plan of care;
2. Medically necessary and appropriate for treatment of the resident ' s condition;
3. In accordance with the prevailing standard of practice in the nursing community;
4. A service that can be safely, effectively, and efficiently provided in the facility;
5. Recorded in nursing progress notes; and
6. In accordance with the resident ' s service plan.
(d) At least monthly, or more frequently if required by the resident ' s service plan, a nursing assessment of the resident shall be conducted.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to adequately assess the status of 1 out of 16 sampled residents (Resident #9), who is cognitively [illegible] requires total assistance for activities of daily living, to be admitted under their Extended Congregate Care (ECC) license for continued residency or deemed an inappropriate resident under their standard license.

The findings include:

Resident #9 was admitted to the facility on 11/2[illegible] diagnoses to include Alzheimers, [illegible] osteoarthritis.

[illegible]04/1[illegible]10:00 a.m. an interview was conducted with the Administrator who stated they currently do not have any residents under ECC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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
AE207	Continued From page 29	AE207		

(extended congregate care). Review of the ECC log revealed the last resident that was under ECC was in 2009.

On [redacted] at 10:45 a.m., Resident #9 was observed in the main activity [redacted] in a geri chair. The resident was nonverbal and unable to make her needs known. At 10:50 a.m. Resident #9 was observed to be fed juice and cookies by the aide. Resident #9 made no attempts to assist with eating or repositioning in the geri chair and required the assistance of 2 people to reposition her in the geri chair prior to assisting with eating and drinking. At 12:30 p.m. Resident #9 was observed in the dining [redacted] the geri chair receiving total assistance for feeding by an aide. The resident remained nonverbal and made no attempts to assist with eating or communicate in any way. On [redacted] at 9:15 a.m. Resident #9 was observed in the main activity [redacted] the geri chair. The resident remained nonverbal and was observed to be slouching down the geri chair and she made no attempts to reposition herself and required the assistance of 2 people to reposition her higher up in the chair.

Review of resident #9's record revealed a Health Assessment dated [redacted] The assessment documented the resident as being awake, alert and oriented x 1, required assistance with transfer and required assistance with ambulation, eating and activities of daily living. Additionally the assessment documented the resident was on hospice. Further review of the resident's record revealed no evidence of documentation that she was currently under hospice care or at what point since 2011 the resident required the use of a geri chair for mobility or positioning.

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
	AL11942933	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND COURT VILLAGE II	459 RACETRACK ROAD POMPANO BEACH, FL 33060

(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
AE207	Continued From page 30	AE207		

On 04/1 11:15 a.m. an interview was conducted with the DON, who stated Resident #9 was on hospice but was taken off however she was not sure at what point the hospice was terminated. It was noted in the resident's chart a urinalysis was ordered on 03/0 Resident #9 however there were no lab results in the chart. A further inquiry was made to the DON what the results of the urinalysis were and after reviewing the resident's record and looking through papers that still needed to be filed into resident charts, the DON stated it looks like it was not done probably because Resident #9's lower extremities are very contracted and it is difficult to get her legs apart. Further review of the resident's record revealed no evidence of documentation at what point the resident became contracted and totally dependent for activities of daily living and ambulation and positioning.

On 04/1 11:30 a.m. an interview was conducted with the Administrator and DON, who stated they were not aware a resident could not be in a geri chair if they were not under hospice. An inquiry was made as to why Resident #9 was not under ECC taking into account her current physical and cognitive and the Administrator and DON were unable to provide an answer.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Grand Court Village II
459 Racetrack Road
Pompano Beach, FL 33060

Dear Administrator:

This letter reports the findings of a state licensure survey with ECC that was conducted on . 2013 by representatives from this office. Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within **thirty (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924