STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953671	01/09/2017
NAME OF PROVIDER OR SUPPLIER **AM GRAND COURT LAKES, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **280 SIERRA DRIVE** **NORTH MIAMI BEACH, FL 33179**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A Complaint survey started on , 2017 and finished on , 2017 (CCR #s 2016013264 and 2016013541) . Am Grand Court Lakes, Llc license #8390. had the following deficiencies identified at the time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based record review, interview and observation, the Assisted Living Facility failed to have an updated health assessment (AHCA form 1823) that showed four (Resident #6, #10, #2, #14,) out of 22 sampled residents' change in activities of daily living levels.

Findings included:

Review of Resident #6's record revealed that the resident was admitted on / / . Health Assessment (AHCA form 1823) completed on / / showed known to , all pain medications, medical history and diagnoses: and . Physical or sensory limitations: ambulates with power chair or walker. or behavioral status: alert, oriented times 3. Nursing/ treatment/ service requirements: home health services for care. Resident was independent with ambulation, eating, self-care ( ), toileting, and transferring, needed supervision for dressing and assistance for bathing. Special diet precautions: . Resident was not bedridden, did not have a pressure, no communicable , did not pose a danger to self or others, did not require 24-hour nursing or care. Resident was able to self-administer medications without assistance. An interview on / / at 11:54 AM the Director of Nursing (DON) revealed that the resident no longer received care. At 12:01 PM the DON revealed that she'd just called the home health agency and they stated that the resident stopped care on / / .
Review of Resident #10's record revealed that the admission date was on . Health Assessment (AHCA form 1823) completed on showed medical history and diagnoses: , , . Physical or sensory limitations: motor disturbance, ambulatory with wheelchair. or behavioral status: Alert, forgetful. Nursing/ treatment/ service requirements: medication management, assistance with ADLs, hospice services. Special precautions: safety/ precautions, no elopement risk. Resident needed assistance ambulation, bathing, dressing, self-care ( ), transferring, toileting, and dressing, needed supervision with eating. Special diet precautions: no added salt. Resident was not bedridden, did not have , no communicable , did not pose a danger to self or others, did not require 24-hour nursing or care. Resident needed assistance with self-administration. A review of Resident #10's hospice record revealed that she'd received hospice services since admission date , with a diagnosis of . Plan of Care Review showed that resident was dependent for four activities of

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daily living and nursing updated comprehensive assessment completed on / / showed that those activities were ambulation, bathing, dressing, and toileting.
Observation on / / at 9:15 AM revealed that Resident # 14 was on continuous care under hospice services. Staff from hospice was providing baths. Resident #14 received assistance with his Activities of Daily Living (ADL).

Review of Resident #14's record revealed that admission date was /. Health Assessment completed on / / showed medical history and diagnoses of Parkinson ' s , and . Resident was independent with eating, supervision with ambulation, toileting and transferring, assistance with bathing, dressing, and . Resident needed assistance with self-administration of medications. A review of Resident #14's hospice record revealed that he received hospice services since admission date / with diagnosis of Parkinson ' s . Nursing updated comprehensive assessment completed on / showed that Resident had limitations transferring, bathing, dressing, and toileting.

Uncorrected
Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview, the Assisted Living Facility failed to provide care and services appropriate to meet the needs of three (Resident #1, #2, and #3) out of 22 sampled residents. Resident #1 and hips and several ribs after falling out of bed. Resident #2 and sustained five right sided while been transported, unsecured by a seat belt, in the facility van. Resident #3 wandered from the locked Memory Care Unit twice, successfully leaving the facility which prompt the facility to report the resident missing to law enforcment.

Findings included:

Review of facility's internal report completed on / / at 8 AM revealed that Resident #1 was found in the floor in her . A review of progress notes in Resident #1's record confirmed that on / / at 8 AM Resident #1 was found on the floor while staff was doing rounds. Review of facility's internal report completed on / / at 12:55 AM revealed that Resident #1 while climbing over the bed rail. Resident #1 was sent to the hospital.

Review of Resident #1's record revealed that health assessment (AHCA form 1823) completed on / showed resident was . The resident's medical history and diagnoses were ( ), Dyslipidemia. Physical or sensory

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limitations: unsteady gait; identified as needing precautions. Resident #1 needed total care for bathing and dressing, assistance for toileting, supervision for transferring and self-care ( ) and independent for ambulation and eating. Review of Resident #1's hospice record revealed that there was a doctor order for bed rail in place since / /

A review of hospital records showed that Resident #1 was admitted to the hospital on / / . The chest x-ray conducted at the hospital on / / showed that impression was right sided of seventh and eighth ribs, in addition to the hip

Interview on / / at 9:30 AM, the Director of Nursing (DON) revealed that Resident #1 was at the hospital because she out of bed.
Review of Resident #1's hospice record revealed that Resident #1 was admitted to hospice on / / and the same date was placed on continuous care due to and for observation and safety. Nursing assessment completed on / revealed that Resident #1 needed assistance with all activities of daily living, had unstable mobility, and motor changes; resident had limitations with dressing, bathing, positioning, , toileting, transferring, eating and ambulating. Nursing assessment completed on / revealed that Resident #1 had area to upper extremities and needed total care. Continued care was discontinued on / . Hospice identified the resident with precautions. Progress note on / revealed that resident was at the hospital and resident's daughter stated she received a call from the facility saying that the resident was found on the floor with an apparent of her hip.
Interview on / at 1:11 PM via telephone, the Administrator revealed that Resident #1 should have been seen last on the date of the within an hour window because staff did hourly checks. In a further interview on / at 2:39 PM, the Administrator stated that facility could not provide hourly rounds sheets showing when the resident had last been seen because they had problems with documentation.
2)
A review of one-day incident report for Resident #2 completed on / / and then 15-day incident report completed on revealed that on / / at 2:58 PM while being transported in the facility's van back from a doctor's appointment, Resident #2 out of her wheelchair to the floor of the bus. Ambulance (911) was called and Resident #2 was taken to the hospital for evaluation. Resident #2's hospital emergency discharge documents in the record showed diagnoses: of chest wall, right, initial encounter.
A review of one-day incident report for Resident #2 revealed that Resident #2 arranged to see orthopedic due to continued pain after the van accident, and she returned from her doctor's office with a diagnosis of " Sustained several right sided ." A review of Resident #2 ' s orthopedic report from / revealed that X-rays of cage showed multiple right-sided
Review of Resident #2's record revealed that there was a prescription from a doctor dated / /

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stated "Resident #2 has sustained several right-sided due to being involved in a MVA (Motor Vehicle Accident) on / / ."
Review of Driver A's personnel record showed that he was terminated on / due to failure to secure resident while transporting causing on / / .
Interview on / / at 12:12 PM Driver B stated, "I drive in case of emergencies like when there are two appointments at the same time. I received a training when I started. I trained the new drivers. Last training, I provided was like five or six months ago." Further interview revealed that there was an incident while driving another driver two months earlier. Driver B stated that he explained to drivers how to secure the wheelchairs and basic stuff but there was no documentation of any training. There was also no documentation about the incident. He said that Resident #2 explained to him that Driver A did not secure her wheelchair.
An interview on / / at 1:09 PM the Administrator revealed that Resident #2 was involved in a motor vehicle event, it was not an accident. Her wheelchair was not secured and it bent over. The Administrator stated "She went that day to the hospital and had but not . Resident #2 does her own doctor's appointments." The Administrator did not know why Resident#2 went to the orthopedic doctor. The administrator stated "Driver B and C knew the policies and they knew they cannot run the vehicle without residents been secured. We spoke with them but we don ' t have a training."
On / at 3:05 PM Resident #2 stated, "that incident was on / , mid-afternoon, I was coming back from a appointment. The driver and I were speaking about music and then he made a left turn, it was a little fast. I think he was driving too fast. My electric wheelchair tilted over and I was crunched between the wheelchair chair and the lift, when he saw me he stopped and he started saying Resident #2, I am sorry, I am sorry. He called rescue and when they got there they took me to the hospital and in the hospital they told me I had ribs. But when I went to an appointment with my orthopedic doctor for a follow up, (the follow up for a in my right pinky finger from a prior , (I can't remember the exact date) my doctor did an X-ray and that ' s when she told me you have five broken ribs. The doctor told me it takes about 8 weeks to heal and they can't bind them because it causes , ."
Review of Resident #2's record revealed that admission date was on . Health assessment (AHCA form 1823) dated / showed medical history and diagnoses of , , type II, Chronic kidney , Obese, , , , , . Resident was Wheelchair dependent and dependent. Resident needed assistance with ambulation. Resident was independent with bathing, dressing, eating, self-care ( ), toileting and transferring. Resident needed assistance with self-administering medication.
Interviewed on / at 1:11 PM via telephone the Administrator revealed that facility transported around 51 residents and all of them needed to secure while transporting. Further interview on /

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at 2:51 PM revealed that residents used facility's transportation for going to doctors' appointments and stores.
#3)
Review of one-day incident report for Resident #3 completed on and then 15-day incident report completed on revealed that Caregiver B found Resident #3 was found in the facility's lobby wanting to leave when Caregiver B arrived to work.
Review of Memory Care's rounds log revealed that Resident #3 was last time seen on at 2 PM. Resident #3 was not seen on / after 3 PM until / at 6:30 AM.
Review of one-day incident report for Resident #3 completed on / / at 7:30 AM revealed Caregiver A Informed Med Tech B that Resident #3 was not in her . Resident #3 called the facility informing that she lost her way back. Administrator and DON picked her up.
An interview on / / at 1:45 PM the Administrator revealed that Resident #3 left the facility, she went for a walk and couldn't find her way back. The facility called the police and the Resident called the facility. The resident was found about four blocks away. The Administrator stated that Resident #3 was in the memory care unit, which is a locked unit. The resident did not tell anyone that was going out of the facility.
Review of Memory Care's round log revealed that Resident #3 was last seen on / at 10 PM. Resident #3 was not seen on / at 11 PM nor on / / between midnight and 7 AM.
Record review on / found the only staff schedule available for review was dated 2016. The facility did not have 's staffing schedule available for review.
Interview on / / at 3:30 PM with the Administrator regarding which staff were on duty when Resident #2 was missing, the Administrator and the assistant business manager stated that they did not have the staff schedules. The assistant stated, "I had them in the drawer and on a flash drive in the office and now they are gone. I don't know where they are. "
Interview on / / at 1:11 PM via telephone, the Administrator stated regarding Resident #3 " She is very bright, she may know the code to get out of the Memory Care Unit by observing." The Administrator further stated that she did not know if the facility had policies and procedures for the Memory Care Unit. She also stated that the only measure that facility took was to have a regular meeting with staff and reminded them to be cautious when putting in the unit code. The Administrator said " Memory care unit code was change this week." After the second elopement, the facility changed the unit code and re-secure the gate for the memory care unit. She did not know the reason why Resident #3 was in the Memory Care Unit. On / / at 2:36 PM via telephone the Administrator stated that facility had problems with documentation. Resident #3 was very alert and there was no documentation about the last time staff saw Resident #3. Further interview on / at 2:39 PM the Administrator revealed that she assumed that Resident #3 was in the Memory Care Unit because she needed more supervision and that family said Resident #3 has history of elopement.
Review of Resident #3's record revealed that admission date was on / . Health assessment

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(AHCA form 1823) dated I/ showed medical history and diagnoses of , dyslipidemia and acute , . Resident was alert and oriented timed 3, with limited concentration and attention. Resident was independent with ambulation, bathing, dressing, eating, self-care ( ), toileting, transferring. Resident needed assistance with self-administration of medications. The facility failed to ensure that Resident #3 was properly assessed after attempting to leave the facility twice and successfully leaving the facility on I/ I/ . The updated health assessment for Resident #3 did not identify her as an elopement risk. Progress notes showed that resident eloped on I/ / during rounds the resident was not noted in her apartment. The facility searched for the resident. The resident called the facility to be picked up at a local address a few hours later.
Interview on I/ at 2:45 PM via telephone, DON revealed that Resident #3 wore a bright yellow bracelet but it did not have the resident's name nor the facility's address. Further interview on I/ at 2:50 PM revealed that facility had not completed an elopement assessment before or after the elopements.
Interviewed on I/ / at 2:23 PM via telephone, the DON stated that she asked the Administrator on to change the code to the Memory Care unit after the resident eloped the first time, but the code was not changed. When interviewed, the resident told to the DON that she had left the unit via a two-foot gap between the gate and the wall on the unit, or over the top of the gate, where there was another gap. After the client ' s second elopement, the DON asked the maintenance director to close the gaps and to change the code. He did both; placing a bar across the gap that the resident had described leaving through. DON further stated that the resident was found in front of someone ' s house, with a few of her belongings with her, after the second elopement. DON said that she also scheduled a doctor ' s appointment for reevaluation of the resident, and the doctor scheduled to come on 23 and 30, but canceled both times, saying that he would be back on I/ / .

Uncorrected
Class II

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the Assisted Living Facility's staff failed to follow the procedures outlined by the state while providing assistance with self-administration of medication to one of 22 sampled residents (#4). The facility also failed to give all medicines scheduled, and later initialed these medicines as given at 8 AM.

Findings included:

Observation in facility ' s medication I/ / at 9:04 AM revealed that Medication Technician (Med Tech) A assisted Resident #4 with self-administration of medications. Med tech A did not wash her

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hands or use hand sanitizer before starting the procedure. Med tech A opened the drawer in the medication cart and took out medicines already prepackage by the pharmacy. Med Tech A checked medicines with medication observation records (MOR) and they matched. Medicines were:
- 200 mg - take one tablet by mouth twice a day scheduled at 8 am and 5 PM
- 81 mg- take one tablet by mouth daily- scheduled at 8 AM
- Oys Shell 500 mg- take one tablet by mouth twice a day- scheduled at 8 AM and 5 PM
- Carbodopa/Levo / - take one tablet by mouth three times a day- scheduled at 8 AM and 5 PM
- 10 mg- take one tablet by mouth daily- scheduled at 8 AM
- sod 75 mg- take one tablet by mouth twice a day- scheduled at 8 AM and 5 PM
- 40 mg- take one tablet by mouth daily- scheduled at 8 AM
- 20 mg- take one capsule by mouth daily- scheduled at 8 AM
- 40 mg- take one tablet by mouth once a day- scheduled at 8 AM
- 0.125 mg- take one tablet by mouth three times a day- scheduled at 8 AM, 1 PM and 5 PM
- 8.6 mg- take one tablet by mouth daily- scheduled at 8 AM
- D 2000 U- take two tablets by mouth daily- scheduled at 8 AM

Med Tech A did not give milk of magnesia-(take one tablespoon by mouth every day for)- scheduled at 8 AM.
Further observation at 9:09 AM revealed that Med Tech A stood next to Resident #4 and read medicines' names. At 9:10 AM Med tech A opened prepackaged medicines and put them in a little disposable cup and passed it to the resident with a cup of water. At 9:11 AM Med tech A initialed MORs, including initialing the milk of magnesia as given.
Interview on / / at 10:11 AM, Med Tech A stated "We just give it when he is constipated." Med tech A revealed that she did not give the medication to Resident #4 on / / .
Class III
Uncorrected

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and record review, the Assisted Living Facility failed to keep medications locked at all times.
Findings included:
Observation on / at 10:11 AM observed unlocked medication in Resident #11 ' s .
Medication observed was Nasal spray and it was on resident ' s nightstand.
Review of Resident #11 ' s record revealed that admission date was on . Health assessment (AHCA form 1823) dated / showed that the resident needed assistance with self-administration of medications.
Class III

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Uncorrected

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Am Grand Court Lakes, Llc
280 Sierra Drive
North Miami Beach, FL 33179

RE: CCR #2016013264

Dear Administrator:

This letter reports the findings of a complaint state licensure survey that was conducted on 3 through 9, 2017 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) 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 days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2017.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyor(s). Should you have any questions please call Sonia Bailey, Health facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure 2016013264
XG90

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