STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953671	02/13/2017
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 (CCR#2017001183) was conducted on , 13 and 14, 2017. AM Grand Court Lakes, Llc (License # 8390) had deficiencies identified at the time of the survey.

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

Based on observation, record review and interview the facility failed to conduct a new face to face medical examination after a significant change for 1 out of 11 sampled residents (Resident # 2).

Findings included:

On at 10:28 am Resident # 2 was observed in the activities the memory unit seated in a chair bent over and sleepy. Staff U stated that Resident # 2 required total assistance with her activities of daily living and medication administration; he also stated that he is a med tech and that he is the one giving her the medications in her mouth.

Record review of Resident # 2 revealed that the last health assessment was completed on and stated that the resident required supervision with eating and assistance with the rest of her activities of daily living. Also revealed that the resident has been receiving hospice services since with diagnosis of 's . A progress note on the hospice record dated stated that the resident always keeps the same position with her body bent forward and her head bent forward with the neck totally bent and that the staff has to hold the head up in order to feed her and that once they put a spoon of food in her mouth she returns to the same position, also stated that the resident is unable to walk and requires total assistance with personal care and that she is bed bound.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review and interview the facility failed to honor the right of one out of 11 sampled residents to be free of (Resident # 1). The resident was restrained by a full bed rail which she could not remove.

Findings included:

During tour of the facility on Resident # 1 was observed in her 11:12 am lying in bed with full side rails up. The resident was unable to remove the rails without assistance from staff.

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On at 12:30 pm asked the Administrator if Resident # 1 was under hospice services and she stated, "no"; when questioned why she had full side rail, the Administrator stated, "She had full side rails?"

Record review revealed that Resident # 1 had a prescription for half side rail written on and the consent for half side rail was signed by the resident but it had no date.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation and interview the facility failed to have a licensed staff to administer medications to a resident that requires the medications to be administer (Resident # 2).

Findings included:

On at 10:28 am Resident # 2 was observed in the activities the memory unit seated in a chair bent over and sleepy.

Staff U stated that Resident # 2 required total assistance with her activities of daily living and medication administration; he also stated that he is a med tech and that he is the one giving her the medications in her mouth.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review wand interview the facility failed to proof that staff who provide direct care to residents, who have not taken the core training program, received a minimum of 1 hour in-service training within 30 days of employment in Resident rights in an assisted living facility and recognizing and reporting resident , neglect, and , for one out of 25 sampled staff (Staff H).

Findings included:

Record review revealed that Staff H was hired on and that there was certificate to prove that she took a 1 hour in-service training within 30 days of employment in Resident rights in an assisted living facility and recognizing and reporting resident , neglect, and , .

On at 3:05 pm during the exit conference the administrator stated that Staff H took the missing

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training but that it is probably not filed in her record and that they will look for it.

Class III