STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911412	R 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVEWELL AT COURTYARD PLAZA	**15520 NW 2 AVENUE** **NORTH MIAMI BEACH, FL 33160**

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

0000 - Initial Comments

A Full Monitoring Survey Revisit was conducted on 08 and 09, 2017. Livewell at Courtyard Plaza (license # 7169) with Limited Nursing Services and Limited Mental Health had an uncorrected deficiency identified at the time of the survey.

A Standard Biennial Revisit Survey was conducted on 8th - 9th, 2017. Livewell at Courtyard Plaza (AL#7169) with Limited Nursing Services and Limited Mental Health components 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 record review and interview the facility failed to update health assessments for Resident #22's health significant changes.

Findings included:

Observation on ... at 12:16 pm showed Resident #22 (admitted on ...) was eating her puree lunch.

Record review on revealed that Resident #22's health assessment (dated on) did not have information about her diet. Further review of the file showed that Resident #22's weight130 pounds on , 114 pounds on , but was 112 pounds on . "Progress notes stated that PCP notified of weight loss and continue monitoring."

Interviewed on ... at 2:55 pm, Staff A revealed that she did not know about Resident #22's health assessment missing information about her diet."

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation, interview and record review, the facility failed to provide documentation of a therapeutic diet prescribed for one of one sampled residents (Resident #22).

Findings:

Observation on ... around 12:26 pm revealed that Resident #22 was eating a puree diet.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911412	R **03/09/2017**
NAME OF PROVIDER OR SUPPLIER **LIVEWELL AT COURTYARD PLAZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **15520 NW 2 AVENUE** **NORTH MIAMI BEACH, FL 33160**	

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

A record review on revealed that there was no documentation of a doctor order indicating a puree diet for resident #22.

Interviewed on at 12:26 pm Staff L stated, "Resident #22 eats her meals as puree; she has no , and it is better for her."

Interviewed on at 3:20 pm revealed that Staff A acknowledged that resident #22 did not have a Doctor's order for puree diet.

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on observation, interview and record review, the facility failed to ensure that one of 17 sampled staff had the required three hours of Limited Mental Health training (Staff K).

Findings

Observation on revealed that Staff K (hired) was passing snacks to the residents at 8:00 pm.

Record review on revealed that Staff K did not have the three hours of training in Limited Mental Health in her file at the time of the survey.

Record review on revealed staff Initial 8 hours on LMH training was on for 8 hours.

Interview on at 8:50 pm revealed staff A stated, "Staff K is working at the first floor area today."

Interview on revealed staff A stated, "Staff K took her update, but I do not know why her name is not reflected on the training list and/or her file. Staff A acknowledged that Staff K did not have her three hours of LMH training at the time of the exit conference.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911412	R 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVEWELL AT COURTYARD PLAZA	**15520 NW 2 AVENUE** **NORTH MIAMI BEACH, FL 33160**

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

0000 - Initial Comments

A Standard Biennial Survey Revisit was conducted on 08 and 09, 2017. Livewell at Courtyard Plaza (license # 7169) with Limited Nursing Services and Limited Mental Health 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 record review and interview the facility failed to update health assessments for Resident #22's health significant changes.

Findings included:

Observation on at 12:16 pm showed Resident #22 (admitted on) was eating her puree lunch.

Record review on revealed that Resident #22's health assessment (dated on) did not have information about her diet. Further review of the file showed that Resident #22's weight130 pounds on , 114 pounds on , but was 112 pounds on . "Progress notes stated that PCP notified of weight loss and continue monitoring."

Interviewed on at 2:55 pm, Staff A revealed that she did not know about Resident #22's health assessment missing information about her diet."

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation, interview and record review, the facility failed to provide documentation of a therapeutic diet prescribed for one of one sampled residents (Resident #22).

Findings:

Observation on around 12:26 pm revealed that Resident #22 was eating a puree diet.

A record review on revealed that there was no documentation of a doctor order indicating a puree diet for resident #22.

Interviewed on at 12:26 pm Staff L stated, "Resident #22 eats her meals as puree; she has no

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	AL11911412	R 03/09/2017
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

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Interviewed on at 3:20 pm revealed that Staff A acknowledged that resident #22 did not have a Doctor's order for puree diet.

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on observation, interview and record review, the facility failed to ensure that one of 17 sampled staff had the required three hours of Limited Mental Health training (Staff K).

Findings

Observation on revealed that Staff K (hired) was passing snacks to the residents at 8:00 pm.

Record review on revealed that Staff K did not have the three hours of training in Limited Mental Health in her file at the time of the survey.

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