STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911412	R 05/09/2017

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 monitoring revisit survey was conducted in conjunction with a complaint survey (Aspen ID VIIO11) from , , 2017 to , , 2017. Livewell at Courtyard Plaza (license # 7169) with Limited Nursing Services and Limited Mental Health 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 on observation, record review and interview, the facility failed to update health assessments for two of 28 sampled residents after significant health changes (Resident's #21 and #16).

Findings included:

On at 9:53 A.M., observed at the entrance of that Resident #21 was in a plastic bottle behind a transparent patio chair. Staff A, resident care director was present performance tour she acknowledged the incident, she walked to # and called Staff M, certified nursing assistance (CNA) to assisted resident #21. Staff M arrived, held the resident hands and walked him into the , stating "he is legally and he needs our assistance for everything." Observed that Resident #21 was able to transfer with staff assistance inside # . Staff sat Resident #21 in the wheelchair and stated "I will assist him with toileting." Staff A informed the CNA that the resident had a plastic bottle with in his jacket pocket.

Record review revealed that Resident #21's health assessment (AHCA 1823 form) dated on showed diagnoses: arm gunshot , numerous shaft , chronic confessional status with physical or sensory limitation " ." The resident needed assistance with activities of daily living (ADL's); was listed as independent with ambulation, dressing, eating, and toileting and transferring; needed supervision with bathing and assistance with self-care.

On at 8:30 A.M. was observe Resident #16 struggle with a rolling walker into the dining breakfast. At 7:38 A.M a resident in the dining .

A review of Resident # 16's health assessment (AHCA 1823 form) dated showed diagnoses of with early , , . The resident had a history of acute failure and rhabdomyolysis, resolved; and history (HX) of and , , ( )-controlled, or behavioral status" , ."The resident needed " Precautions." Resident #16's activities of daily living (ADLs) stated that he needed supervision with ambulation, bathing, dressing, toileting and transferring. The resident was independent with eating and self-care.

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During an interview on at 11:01 A.M. Staff A stated that Resident #16 once in the courtyard. "He missed the chair and he . It is was recently that incident happened like two weeks ago. When I get there he was sitting up already." Staff A acknowledged that record dot not contain progress notes regarding the resident's change in condition or incidents.

Class III

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

Based on observation, record review and interview, the facility failed to have documentation of the Home Health plan of care for 1 of 28 sampled residents (Resident #18).

Findings included:

Observation on at 9:15 a.m. revealed that Resident #18 was receiving home health services. A record review revealed that Resident #18's files (facility and home health agency) did not have a plan of care.

During an interview on at 11:57 A.M. Staff A acknowledged that Resident #18's file did not have the care plan. She went to the office to look for the documentation. The plan of care was faxed to the facility by a home health agency on , for a period of to . The resident had sacral area .

Class III.

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

Based on observation and record review, the facility failed to ensure that one of 11 sampled staff (Staff H) had received the required three hours of continuing education training in Limited Mental Health (LMH) biennially.

Findings:

On between 7:51 am and 12:25 PM, observed Staff H providing various kinds of personal care and assistance to the facility's LMH residents, including assistance with self-administration of medications.

A review of the personnel record revealed that Staff H (hired) had received eight hours of initial LMH training on . There was no documentation that Staff H had received the required three

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SUMMARY STATEMENT OF DEFICIENCIES
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hours of continuing education training in Limited Mental Health biennially.

Class III