STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953671	R 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AM GRAND COURT LAKES, LLC	**280 SIERRA DRIVE** **NORTH MIAMI BEACH, FL 33179**

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

0000 - Initial Comments

A Fourth Revisit Survey was conducted on 05/11/2017. 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 on record review and interview, the Assisted Living Facility failed to have an accurate health assessment for 7 out 11 sampled residents (Resident #1, #2, #4, #6, #7, #8, and #11).

Findings included:

A review of Resident #1's file showed the resident was admitted on , AHCA Health Assessment dated ; showed resident has diagnoses of High , ( ), , ( ), ( ), Aphasia, History of arm and right foot bone. The resident ambulates with wheelchair/cane. The resident was alert & oriented, periods of forgetfulness. Per Health Assessment the resident is not an elopement risk. The resident is independent with ambulation, needed assistance with bathing and dressing, independent with eating, needed supervision with self-care ( ), is independent with toileting and transferring. The resident required a no added salt diet. The resident needed assistance with self-administration of medications.

On at 10:47 AM Resident #1 stated "I do not remember when I but how I a few days ago was that I was trying to walk out to the porch and I tripped from the small rail of the sliding door. I do not remember when in the , I because I was unable to get up."

A review of facility's incident report revealed: on 4:00 PM, Resident #1 in his , trying to take a shower, has a raised area on the right side of his head. The resident denied any pain or discomfort. the resident refused treatment.

A review of Resident #2's file showed the resident was admitted on AHCA Health Assessment dated ; showed resident has diagnoses of Diastolic , , Parkinson's , Spinal , , pectoris, , ( ), Major , , Seborrheic , History of . The resident ambulates with a wheelchair. The resident is Awake, Alert, Oriented x 3 with memory loss, and receives Hospice services. Per health assessment the resident is not an elopement risk. The resident needed assistance with ambulation, bathing, and dressing, the resident is independent with eating, need assistance with self-care , toileting, and transferring. The resident required a no added salt diet. The resident needed assistance with Self-Administration of Medications.

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On at 11:06 AM Resident #2 stated "I do not remember when I had the , but I remember I slid off the chair in the , no I did not have to call anyone, the afternoon shift found me. I was on the floor probably about 15 minutes, and they called the rescue department and I was taken to the hospital by ambulance."

A review of facility's incident report revealed that on at 2:50 AM Resident #2 was found on the floor, he said he got out of bed and was going to the .

A review of Resident #4's file showed the resident was admitted on , Bed rail consent in file signed by resident. AHCA Health Assessment dated , showed the resident has diagnoses of Essential Primary , , Memory loss, . Physical or sensory limitations: wheelchair, Motor disturbance. or Behavioral status: Awake, Memory loss, disoriented to place and time. Per Health Assessment the resident was not an elopement risk. The resident needed assistance with ambulation, bathing, dressing, eating, self-care ( ), toileting, transferring. The resident required a no added salt diet. The resident needed assistance with self-administration of medications.

On at 10:21 AM Resident #4 stated "I am not able to walk, I am mostly in bed. The staff person they help me with bathing and dressing. The food is served in my ; I always eat in my . Yes, I had a from my wheelchair, but I do not remember."

A review of Resident #6's file showed the resident was admitted on AHCA Health Assessment dated , showed resident has diagnoses of , , , , , ambulates with wheelchair or walker. The resident is oriented X 2. Per health assessment the resident was not an elopement risk. The resident was independent with ambulation, needed assistance with bathing, supervision with dressing, independent with eating, supervision with self-care ( ), toileting, transferring. The resident required a regular diet. The resident needed assistance with Self-administration of medications.

On at 11:30 AM interview with Resident #6 stated "Yes, I had a , because I suffered a mini . I was walking on the catwalk (Hallway), to get to the door and I lost control of my limbs. I didn't have to call, I have a life alert necklace and a bracelet and I was able to press for help. I was on the floor because I lost control of my limbs; all I remember was that Fire Rescue arrived to pick me up. I was taken to Jackson North hospital. Yes, they sometimes provide assistance with bathing and dressing, I would have to call them. I am able to ambulate with a cane, with a little bit of difficulty."

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A review of Resident #7's Form 1823 AHCA Health Assessment dated showed the resident needed assistance with bathing.

On at 11:23 AM Resident #7 stated "No, I do not remember much of the . I was in the out of the shower and I , I hit my face and I was from my nose. The 3-11 PM Shift found me. They found me on the floor and I was taken by the emergency department to the hospital. I do not think I was left there for a long time because I was found on the floor right away and they called the ambulance."
A review of the facility's incident report showed on the Resident #7 had a and had a in the .

On at 7:30 AM during facility tour observed in Resident #8's in electric chair, there was a strong odor in .

A review of Resident #8's file showed the resident was admitted on , AHCA Health Assessment dated , showed the resident has diagnoses of , , ( ). Physical or sensory limitations: ambulates with power chair or walker. or behavioral status: Alert oriented x 3. The resident was independent with ambulation, needed assistance with bathing, needed supervision with dressing, and was independent with eating, self-care ( ), toileting, and transferring. The resident required a diet. Per Health assessment the resident was able to administer without assistance.

On at 11:47 AM Resident #8 stated "Yes, I had an accident, I was at Publix and I was hit by a van while I was crossing on Ives Dairy Road, the driver didn't stop and he hit me. I was taken to Aventura Hospital. No, I do not remember the exact date. They discharge me because I only had minor injuries and lower back pain. I am able to change my clothes, but I get scared of falling in the , I will give myself a sponge bath. Yeah, the staff will assist, but I am very heavy so I try to do much on my own."

On at 11:47 AM during interview observed Resident #8's pants had wet stains on his pants. Review of Resident #11's record revealed that Health assessment (AHCA form 1823) completed on showed medical history and diagnoses: , , and under nursing/treatment/ , service requirement that hospice services provided medicines management while later in showed that resident needed assistance with self-administration of medications.

On at 12:13 PM interview with Director of Nursing stated "Resident #8 refuses to take a shower, after the accident I explained to him how important it is to be bathe and keep clean, and he

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cooperated that one time, but afterwards he continued to refuse to shower. I have not informed this to the doctor because I felt this was a right the resident had, to refuse to shower."

Aeview of Resident #11's hospice record showed diagnoses: . . . . . , ... without behavioral disturbance.

On at 1:22 PM, the Director of Nursing revealed that facility will contact the hospice company for their doctor to complete a new health assessment.

Uncorrected
Class III

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

Based on observation, record review and interview, the facility failed to provide care and services appropriate to meet the needs of residents. The facility failed to provide adequate daily observation and personal supervision to prevent resident with injury for 4 out 11 sampled residents (Resident #1, #2, #7, and #10).

Findings include:

A review of Resident #1's file showed the resident was admitted on . . . . . , AHCA Health Assessment dated ; showed resident has diagnoses of High , ( ), , , ( ), ( ), Aphasia, History of arm and right foot bone. The resident ambulates with wheelchair/cane. The resident is alert & oriented, periods of forgetfulness. Per Health Assessment the resident is not an elopement risk. The resident is independent with ambulation, needs assistance with bathing and dressing, independent with eating, needs supervision with self-care (. . . .), is independent with toileting and transferring. The resident required a no added salt diet. The resident needed assistance with self-administration of medications.

On at 10:47 AM Resident #1 stated "I do not remember when I but how I a few days ago was that I was trying to walk out to the porch and I tripped from the small rail of the sliding door. I do not remember when in the , I because I was unable to get up. No, I did not go to the hospital because I did not have any injuries. I use in my wheelchair, but I can get up and walk."

A review of facility's incident report revealed: on . . . . . 4:00 PM, Resident #1 in his . . . . . , trying to take a shower, has a raised area on the right side of his head. The resident denied any pain or discomfort. . . . . the resident refused treatment.

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A review of Resident #2's file showed the resident was admitted on AHCA Health Assessment dated ; showed resident had diagnoses of Diastolic , , Parkinson's , Spinal , , pectoris, , ( ), Major , , Seborrheic , History of . The resident ambulates with a wheelchair. The resident was awake, alert, oriented x 3 with memory loss, and receives Hospice services. Per health assessment the resident is not an elopement risk. The resident needs assistance with ambulation, bathing, and dressing, the resident is independent with eating, need assistance with self-care , toileting, and transferring. The resident required a no added salt diet. The resident needed assistance with Self-Administration of Medications.

On at 11:06 AM Resident #2 stated "I do not remember when I had the , but I remember I slid off the chair in the , no I did not have to call anyone, the afternoon shift found me. I was on the floor probably about 15 minutes, and they called the rescue department and I was taken to the hospital by ambulance."

A review of facility's incident report revealed that on at 2:50 AM Resident #2 was found on the floor, he said he got out of bed and was going to the .

A review of Resident #7's Form 1823 AHCA Health Assessment dated showed the resident needed assistance with bathing.

On at 11:23 AM Resident #7 stated "No, I do not remember much of the . I was in the , out of the shower and I , I hit my face and I was from my nose. The 3- 11 PM Shift found me. They found me on the floor and I was taken by the emergency department to the hospital."
A review of the facility's incident report showed on the Resident #7 had a and had a in the .

On at 11:17 AM Resident #10 stated "Yes, I had a ; I was walking on the porch. I was feeling a little , and I tripped on my feet. No, I did not have any injuries, but they took me to the hospital. I usually use my wheelchair, but I am able to walk with some difficulty. They will help when I ask them, but I have to call them. "

Uncorrected
Class III

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

Based on observation, interview and record review, the Assisted Living Facility failed to ensure that staff members assisting residents with assistance of self-administration of medication follow the procedures outlined by the state.

Findings included:

Observation on at 7:39 AM revealed that while (Medication Technician) Staff T washed her hands, she touched the faucet while turning the water off. Staff T then went to the medication cart, checked the prepackaged medicine pack with the medication observation record. When she removed the prepackaged medicine packs for Resident #9 from the medicine cart, one pill out in the floor. Staff T went the dining area where Resident #9 sat, read the prepackaged medicine pack including the name of the pill that in the floor and gave the resident the cup with pills, and a cup with water, and waited until the resident swallowed the medicines. No drops were given to Resident #9. Staff T returned to the medication cart and initialed the Medication Observation Record (MOR) including the eye drops and the pill that on the floor, which were not given. Further observation at 7:41 AM revealed that Staff T was shown the pill on the floor, and the pill was discarded by the Housekeeping Unit.

On at 7:53 AM, when asked if Resident #9 took or received any other medicine besides what was observed, Staff T answered, "those were the only medicines I gave her". Further interviewed at 7:58 AM, Staff T stated, "We don't give eye drops in the dining . I overlooked it."

Observation on at 7:59 AM showed that by matching the pills in the floor with Resident #9's medications, the pill on the floor was identified as , 20 mg tablet.

A review of Resident #9's MORs revealed that Med-Tech T initialed , 20 mg on as given at 8 AM.

A review of the facility's hand washing procedures revealed that after hand washing the staff should dry their hands with a clean paper towel and use a paper towel to turn off the faucet.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that staff members updated accurately the Medication Observation Record after assisting residents with self-administration of medications.

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Findings included:

Observation on at 7:39 AM revealed that while Med-Tech T took out prepackaged medicine packs for Resident #9 from the medicine cart, one pill out in the floor. Med-Tech T went the dining area where Resident #9 sat, read prepackaged medicine pack and gave the cup with pills and a cup with water, waited until resident swallowed the medicines. No drops were given to the Resident #9. Med-Tech T returned to the med cart and initialed the MOR including eye drops which were not given and the pill that in the floor. Further observation at 7:41 AM revealed that the surveyor showed to Med-Tech T the pill in the floor and pill was discarded the Housekeeping U.

Review of Resident #9's MORs revealed that Med-Tech T initialed AC 1% eye drop on as given at 8 AM.

An interview on at 7:53 AM the Med-Tech T answered when was asked if resident took or received any other medicine beside that what was observed by surveyor, "those were the only medicines I gave her" (Resident #9). Further interview at 7:58 AM the Med-Tech T stated, "We don't treat eye drops in the dining. I over looked."

By matching the pills in the floor with Resident #9's meds, find out the the pill in the floor was , 20 mg tablet.

Review of Resident #9's MORs revealed that Med-Tech T initialed , 20 mg on as given at 8 AM.

Class III

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

Based on observation and interview, the Assisted Living Facility failed to ensure that staff members disposed medicines in a safe manner.

Findings included:

Observation on at 7:39 AM revealed that when Staff T took out prepackaged medicine packs from the medicine cart, one pill out in the floor from resident # 9. Staff T returned to the medication cart and initialed the Medication Observation Record (MOR), including eye drops which were not given and the pill that on the floor. Further observation at 7:41 AM revealed Staff T was shown the pill in

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the floor. Staff T called Housekeeping Staff U, who wore gloves, picked the pill up and put it in the regular trash can.

On at 10:57 AM, the Housekeeping Staff U stated, "I threw it in the trash can next to where meds were given by nurses."

Class III
Uncorrected

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on observation and interview, the Assisted Living Facility's staff failed to serve lunch in a sanitary manner.

Findings included:

Observation on at 12:19 PM revealed that Waitress V was serving chicken casserole and plates were covered. One of the plates' cover on the floor. Waitress V picked up that plate cover and placed it back atop the plate; Waitress V served that plate with the dirty cover to Resident #13.

On at 3:38 PM the Dietary Management revealed that kitchen staff including waiters and waitresses will be retrained on cross-contamination and cleaning.

Class III
Uncorrected

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on observation and record review, the facility failed to file a one day incident report and a 15 day incident report for 1 out of 11 sampled residents (Resident #7)

Findings included:

A review of the facility's incident report showed the following:
On Resident #7 suffered a in the , and was through her nose.

A review of the AHCA Internal website revealed there was no incident reported completed for Resident #7.

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Class III

Z824 - Right of Inspection; inspection reports - 408.811 FS, 59A-35.120 FAC

Based on observation and interview, the facility failed to provide access to the facility for an unannounced inspection. No staff was available at the facility's entrance or by telephone to allow entrance.

Findings:

On at 6:00AM, observed that the door to the facility was locked. There was no doorbell, and no answers to knocks on the door. Further observed that telephone calls to the facility's main telephone number at 6:03AM and 6:04 were not answered, and voicemail at this number stated that the extension was no longer valid. Observed that no one was working at the facility's front desk.

On at 6:20AM, when asked how emergency personnel or others were able to gain access to the facility in case of emergency, The front desk Security Guard did not respond. He stated that facility's doors were locked from 11 PM to 7AM, and that he let people into the building if they arrived between those hours. He further stated that he had been right near the desk the whole time, and that he always carried a portable phone with him. When asked why it had not been possible to reach any personnel inside of the building at 6:00AM, the Security Guard stated that he had taken a break to use the microwave.

On at 7:20AM, the Property Manager stated that a doorbell would be installed to allow visitors or emergency personnel to contact staff to gain access to the building. He further stated that he had checked the portable telephone to make sure it was working, and that he would correct the voicemail message which said that the facility's main telephone line was no longer valid.

On at 4:50 PM, observed that the facility had installed a doorbell.

Unclassified