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	AL11953384	**03/07/2018**
NAME OF PROVIDER OR SUPPLIER **COURTYARD MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **140 W 28 STREET** **HIALEAH, FL 33010**	

SUMMARY STATEMENT OF DEFICIENCIES
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Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and interview, the facility failed to have a signed copy of the attestation of compliance with background screening requirements in file for two out of 13 sampled staff (Staff E, Staff G, and Staff H).

Findings included:

A review of the facility's personnel files revealed that Staff E hired on 11/ , Staff G hired , and Staff H hired on did not have a signed copy of the attestation of compliance with background screening requirements on file.

On At 1:36 PM Staff B brought Staff E's signed attestation of compliance with background screening and placed it in the file.

During the exit interview on at 3:07 PM, Staff B acknowledged that Staff G and Staff H did not have a signed attestation, but did not state the reason why they did not have it.

Unclassified

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0000 - Initial Comments

A Biennial Standard Survey was conducted on and concluded on . Courtyard Manor Retirement (5947) with Limited Mental Health component had deficiencies identified at the time of the survey:

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on interview, observation and record review, the Assisted Living Facility (ALF) failed to assist residents with arrangements for health care services for six out of 39 sampled residents (#2, #16, #21, #23, #25, and #33). Resident #2 had secretions observed coming from his left big toe, resulting in hospitalization. Resident #21 was a and was hospitalized six times in the last four months; three out of six hospitalizations were for low sugar levels. Resident #16 had a hip and did not have follow up care. Resident #25 had a of the left medial pubic /pelvis. There was no documentation these residents received follow up care with a primary care physician (PCP).

The findings included:

1) Review of Resident #21's record showed the admission date was . The health assessment (AHCA Form 1823) completed on revealed, a medical history and diagnoses of a left above the knee amputation, ( ), ( ), HBP (High), type 2 (Type 2), ( ), and . The or behavioral status was: depressed and . Nursing/ treatment/ service requirement: supervise medications. Special precautions: precautions. The resident was independent for ambulation, eating, toileting, and transferring, needed supervision for self-care and assistance for bathing and dressing. The resident had a regular diet. The resident needed assistance with self-administration of medication.

Resident #21 was admitted to the hospital from to . The discharge summary revealed, the resident arrived at the emergency of , and abnormal breathing. The resident was diagnosed with acute exacerbation, insufficiency, and acute distress. The resident was admitted to the ( ) due to acute distress with some status post acidosis, and . The resident was discharged from the hospital and instructed to

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follow up with , and pulmonologist; to follow up with a primary care physician within 2-3 days and home health care for a (Physical) evaluation, RN (Registered Nurse) monitoring and ADL (Activity of Daily Living) services. The resident arrived to the hospital on at 11:21 AM with difficulty breathing.

Review of Resident #21's facility record revealed, there was no documentation that the resident received follow up care with a , pulmonologist, primary care physician, home health care for a (Physical) evaluation, RN (Registered Nurse) monitoring and ADL services.

Resident #21's ambulance report revealed on at 3:54 PM, residents sugar level was 28 mg/dl(milligrams/deciliter). The resident was admitted to the hospital from to with a diagnosis of Severe . On at 6:00 PM, the resident was still (a low sugar level) after receiving two doses of D50W (50% in Water). The Sugar Level (BSL) was 43 mg/dl on at 4:43 PM, 48 mg/dl at 4:44 PM and 46 mg/dl at 5:41 PM.

Review of Resident #21's discharge documents that were in the facility revealed, the residents discharge diagnoses was severe was discharged from the hospital on with instructions to follow up with PCP (primary care physician) within one week.

Review of Resident #21's hospital record revealed, the Resident was admitted on and discharged on . The resident arrived at the hospital with difficulty breathing. The resident had a Computed Tomography (CT) of the Abdomen and Pelvis without contrast and X-ray of chest that showed results of and .

Review of Resident #21's discharge documents available in the facility revealed, the residents discharge diagnoses were , , and . The resident was discharged from the hospital on with instructions to follow up with the PCP (primary care physician) within one week. The resident was discharged with a diet. A copy of the hospital discharge information sheet for food interaction revealed, the resident had to follow a diet at home.

Review of Resident #21's ambulance record revealed on at 5:29 PM BSL was 49 mg/dl.

Review of Resident #21's hospital record revealed, the resident was admitted on and discharged on . The discharge summary revealed an admitting diagnosis of , , ( ). The final diagnoses were: , , with acute lower , , acute kidney failure, type 2 with without , type 2 with with chronic kidney , chronic .

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exacerbation, hypo-osmolality, hyponatremia, hypertensive chronic kidney through and chronic kidney . The resident was admitted to the ( ) due to acute , distress with some status post lactic acidosis, , and hypoxemic non- -dependent , failure with suspicion for systemic inflammatory response , microcytic , lactic acidosis, acute failure, mild hyponatremia, , and history of , and .

Review of Resident #21's discharge summary from the hospital and found in the facility's record revealed, the residents discharge diagnoses were exacerbation, , lactic acidosis, , ( ) and , . The resident was discharged from the hospital on with instructions to follow up with PCP within 2-3 days. The comment section showed: with HHC (home health care) for (physical ,), RN monitoring, must follow-up with PCP within 2-3 days.

Review of Resident #21's ambulance record showed on at 5:16PM the residents sugar level was 44 mg/dl.

Review of Resident #21's hospital record revealed, the resident was admitted on and discharged on . The admission diagnoses were and .

Review of Resident #21's discharge documents in the facility revealed, discharge diagnoses of and from the hospital on . Special instructions showed: follow up with PCP within 2-3 days. Home Health care for RN monitoring, must follow-up with the PCP (primary care physician) within 2-3 days.

Review of Resident #21's ambulance record revealed on at 3:55PM, the Resident was alert and oriented times (X) zero, and had deep snoring. The residents sugar level was 42 mg/dl.

Review of Resident #21's hospital record revealed, the resident was admitted on and discharged on with diagnoses of and . The resident was discharged with a diet- ADA (American Association) 1800 kcal (Kilo-calories) and follow up with ( ), (-) and endo ( ), ASAP (As Soon As Possible).

A review of Resident #21's facility record showed the only note related to the PCP in the facility was on in the shift report for 3PM-11PM, and showed the MD 'passed by'.

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Review of Resident #21's facility progress notes revealed:
On - Resident observed to be having hallucinations.
On - Resident returned from hospital with discharge documents and scripts (prescription) sent to pharmacy.
On - A resident went to the office and informed staff a resident was sitting outside a was drooling. Staff found the resident drooling and unresponsive. Staff called 911 and transferred the resident to the hospital.
On - Resident #21 returned from the hospital with discharge papers, but no scripts.
On - Resident #21 complained of not feeling well. The resident had . The medical doctor (MD) was called to evaluate the resident. The Resident was transferred to the hospital.
On - The resident returned from the hospital with discharge papers and scripts sent to the pharmacy.
On - The night shift reported to the morning shift, staff saw the resident was unresponsive. Staff called 911 and transferred the resident to the hospital at 5:30 AM.
On - The resident returned from the hospital with discharge papers but no scripts.
On - The resident's went to the office and informed the staff the resident was screaming and making several hand movements. The staff found the resident laying in bed screaming, but staff weren't able to understand the resident. The rescue staff/911 staff was called and transferred the resident to the hospital. The residents friend was notified.
On - The resident returned from the hospital and brought discharge papers with him.
On - The resident started to receive home health services for sugar monitoring.
On - The progress notes did not show the Resident saw the Primary Care Physician after the hospitalization.
On at 3:50 PM - The resident's went to staff and reported Resident #21 was not acting right. Staff went to the saw Resident #21 foaming from mouth and unresponsive. Staff called 911 and rescue staff took the resident to the hospital.

In an interview on at 11:16 AM with the Administrator it was stated, "We sent resident #21 to the hospital, informed the doctor, and asked the doctor to follow up. The supervisor was responsible to review the record, do the changes and follow up. The supervisor was responsible to inform the doctor. It is pretty much from the same thing Resident #21 has been going out.

In an interview on at 11:29 AM, the Administrator revealed, the Supervisor was new, and said 'Staff F missed it.'

Resident #21 was taking 500 mg twice a day and , 2 mg daily for

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management.

In an interview on at 11:38 AM with the facility administrator, about knowing whether the resident had any changes prior to the hospitalization on , the Administrator stated, "if it is not documented I don't know." At 11:43AM the Administrator revealed, the resident received home health services for sugar monitoring, but insurance approved the monitoring for twice a week.

2) Review of Resident #2's Health assessment (AHCA form 1823) completed on revealed a medical history and diagnoses of ( ) and ( ). Physical or sensory limitations: ambulates with a cane. or behavioral status: none. The resident was independent for all activities of daily living except for self-care, the resident needed supervision. The resident needed assistance with self-administration of medications.

During an interview on at 11:36 AM Staff B stated, "Resident #2 is very independent and does not have any family members. Resident #2 does not have any wounds. Resident #2 walks just fine."

During an interview on at 11:46 AM Resident #2 stated, "My toe has been like that for a month, it hurts and pus is coming out. I told 5 people that I have it and it is getting worst and worst. I can't walk, when I put my left foot down, it hurts."

In an interview on at 11:50 AM the Administrator stated, "I did not know about it." Resident #2 saw a Podiatrist already, and I will call him again to see him."

During an interview on at 1:40 PM Resident #2 stated, "The toe hurts and it has secretions."

Interview and observation on at 1:42 PM revealed, Resident #2 pressed the right great toe and it drained fluid, but the surveyor was unable to see the color of the drainage because resident #2's three light switches and only one turned on and the light was dim. Resident #2 reported, he went to the doctor who made some cut in the toe, but it was worst. The resident reported, he has not received and the toe hurt when he walked, slept, and pressed the toe. The resident reported he hasn't seen any doctor recently.

During an interview on at 1:50 PM the Administrator revealed, the resident saw the podiatrist last month, but the facility staff did not have any report about the visit. The administrator reported the doctors did not give any report to the facility. It was revealed the resident already had an appointment for

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the next day with the podiatrist. At 2:02 PM on it was revealed, the resident started complaining about his toe about one week ago.

Review of Resident #2's record revealed, the resident had received care in the past. The communication log for home health revealed, the resident received care from to . The last entry was on and showed the had healed and the resident was discharged.

The facility's progress notes for Resident #2 revealed:
On - The resident went to the podiatrist because the nail of the right toe hurt and the resident returned with a script (Prescription) for home health for a few days and they removed part of the toenail.
On - The resident had a toenail removed a couple of days ago but was doing just fine.
On - The resident's toenail was much better and almost fully recovered.
On - The resident's toenail was fully recovered.

Review of resident #2's record revealed, there was a doctor's order signed on for home health care to: clean with normal and apply triple to the area x 10 days.

Review of the facility's shift report showed:
On - On the 3-11 shift, resident #2 complained of pain in his toenail and on the 7-3 shift, Resident #2 was complaining of pain in his toe and staff called the podiatrist.

During an interview on at 2:35 PM with the Podiatrist office it was revealed, the Assisted Living Facility (ALF) staff scheduled resident #2's appointment on for the following day, on and the last time resident #2 was seen by the podiatrist was on , , 2017.

Observation on at 2:21 PM revealed, resident #2's right great toe had a yellowish or cream color to the toenail area.

During an interview on at 9:15 AM with the License Practical Nurse (LPN) from the home health agency that provided care to Resident #2 revealed, the last time the resident received care was at the end of 2017.

Review of Resident #2's hospital record revealed, the resident arrived at the hospital on at 4:16PM and was admitted to the hospital at 9:15 PM. The emergency , was an abscess of the first toe on the left foot. Review of the resident's bodily systems showed the resident had pain to the left big toe, it was , and had a discharge. The physical exam noted the resident had pain and

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drainage under the left big toenail. The resident was alert, awake, and oriented to person, time and place. The resident's admission diagnoses included: left big toe , and , . An x-ray done on showed: no acute or . Joint space narrowing and varus deviation of the first MTP ( ) joint. The resident was started on every eight hours of , - 3.375 gm and , (apply to body surface) once a day of , 2%.

Record review revealed previously Resident #2 was admitted to the hospital on and discharged on . The resident was received in the emergency pain. The admission diagnoses were aneurysm and pain. The resident also had diagnoses of Cholelithiasis, ( ), Enlarged . The residents symptoms had started an hour prior and the resident had 4 episodes. The CT of the Abdomen and Pelvis without contrast showed, "significant aneurysmal dilatation of the which needs follow up to rule out any worsening or residual complication because of the patient's increased risk of risk for perforation. cannot be rule out on the non-contrast study".

Review of Resident #2's Health assessment (AHCA form 1823) completed on revealed, the residents medical history and diagnoses included ( ) and (, ,). Physical or sensory limitations: ambulates with a cane. or behavioral status: none. The resident was independent for all activities of daily living except for self-care and needed supervision. The resident needed assistance with self-administration of medications.

Review of resident #2's record revealed, there were discharge instructions from the hospitalization. The residents discharge diagnosis was AAA (Aneurysm) and pain. The follow up instructions required to follow up with the residents primary care physician (PCP) within 5-7 days. There was no documentation that Resident #2 received follow up care with the PCP.

During an interview on at 12:41 PM the Administrator reported, there was no documentation about a doctor seeing the resident. She further stated, staff called the doctor, who recommended to 'just to check the resident's , and ensure it was under regular parameters.' A review of the staff personnel files revealed, none of the staff were a licensed health care provider.

3) Review of resident #25's record revealed, the residents admission date was . The health assessment (AHCA form 1823) completed on showed, a medical history and diagnoses of: Type 2, hypertensive- , , . Physical or sensory: paresthesia, less vision right eye. The resident was independent for ambulation, eating, toileting and transferring, but

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needed supervision for bathing, dressing, and self-care. The resident needed assistance with self-administration of medication. There was no documentation the resident received follow up with a primary care physician(PCP).

A review of the resident's record revealed hospital discharge records which documented Resident #25 was hospitalized from to for a pubic rami . The resident arrived with left hip pain. An x-ray of the left hip showed a possible non-displaced of the left pubic /pelvis. The Pelvic CT completed on showed an acute, , non-displaced of the left medial pubic . An acute, non-displaced of the acetabulum with extension.

Review of the progress notes for Resident #25 showed, on the resident out of bed and refused to be seen at the hospital until 2:00 pm on when the pain became severe. The resident returned from the hospital on and continued to complain of pain, so staff documented they gave resident #25 a wheelchair. There was no documentation that a wheelchair was prescribed for the resident, or that the resident received follow-up care with a PCP.

An interview on , with the resident #25's , Resident #23 reported, he found Resident # 25 on the floor on during the night. He reported, he went to the staff office, but none of the staff on duty spoke English, so he 'pantomimed' (used hand gestures) to tell staff about resident #25. Staff got upset with him because he had walked on the floor they just mopped, so they yelled and gestured at him. He didn't know what they were saying, but they seemed upset. He went to find some other residents to help pick Resident #25 up from the floor. On , Resident #23 woke up during the night to find Resident # 25, gesturing wildly, throwing things around the , and attempting to him. Resident #25 hit Resident #23 in the eye, and because he was smaller than Resident #25, he kicked at him to prevent himself from being struck again.

4) Review of Resident #33's record revealed an admission date of . The health assessment (AHCA form 1823) completed on showed a medical history and diagnoses of: DVA (, Anomaly), (,), (,), Obese, (,), . Imbalance, using a 4 point walker. The resident was receiving home health services for administration. The resident was independent for all activities of daily living except: self-care. Special diet: regular, no added salt, low salt/low . The resident received assistance with self-administration of medications.

Review of Resident #33's Medication Observation Record (MOR) revealed, on , , , , , , , , and the resident refused

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20 mg (milligrams), an medication. The resident refused (a and) 50 mg on , , , , , , and . The resident refused (an medication) on and .

During an interview on at 1:25 PM the Administrator revealed, staff should be calling the doctor and documenting in the progress notes.

A review of Resident #33's progress notes showed, there was no documentation of the medication refusals or of any intervention or coordination with health care providers.

Review of Resident #33's hospital record available in the facility revealed, the resident was admitted on and discharged on . The resident arrived with left hip pain. The resident reported he on a slippery floor. The x-ray of the left hip showed a possible non-displaced of the left pubic . The Pelvic CT done on showed an acute, , non-displaced of left medial pubic and an acute, non-displaced of acetabulum with extension.

5) Resident #23, had a health assessment dated that showed diagnoses of , , , gait disturbance, and hypertensive . The resident was assaulted by his , resident #25 on . His eye was and he went to the hospital, was treated for an eye injury and fitted with an eye patch. There was no follow up with a medical provider found in facility's records. While the residents was moved to another his hospitalization, there was no documentation of Resident #23 receiving assistance regarding the assault.

6) Resident #16's, health assessment dated showed diagnoses of: , ( ), Left side , , gait , , old Accident ( ), , , , , , and , . The resident needed medication assistance, and needed supervision with ambulation.

During an earlier survey, the resident was found to have and the facility was asked to complete an incident report. The incident report documented the resident was hospitalized for a month and three days before returning. Interview on revealed, the resident stated that he had a hip.

Record review revealed, Resident #16's electronic incident report documented, "Incident on Resident is male alert, oriented x 3 ambulatory. On around 2:40 pm Resident advised staff that resident had in his . Staff found resident already on his feet on top of his

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bed. Resident reported he was feeling ok and refused to go to the hospital. On around 9:00 am resident complained of having pain on his left side. PCP was advised and per doctors' orders resident was sent to the hospital. On around 12:40 pm resident returned to facility he was alert oriented x 3 and ambulatory."

Interview on at 12:58 pm Resident #16 stated, "I have two years living here. I do not feel like I exercise my rights. I do not receive physical , to walk again. I am using this wheelchair because I . I used to walk with the assistance of a cane." The Resident #16 stated, "The floor was wet, and I . It was the first time I ; I was in the hospital for about two months. The medical appointments is a joke, the doctors are supposed to come monthly, and they come when they want to come. I went to the hospital three months ago. I slipped in my , and I broke my hips. They did surgery on me, I am using the wheelchair, the facility said that my insurance does not want to cover the , and the facility does not provide that neither. I used to walk with the assistance of a cane.

During an interview on at 1:00 pm, the Administrator confirmed Resident #16 was hospitalized for a and had surgery for a broken hip. The Administrator also reported she had no documentation and/or written information about the resident's broken hip. The Administrator stated, "Resident #16 is not walking with the assistance of the cane because he is afraid and he is refusing to walk. The doctors told me that he is doing well. I have no documentation that reflected he could walk and/or he is doing well."

There was no follow up with a medical provider found in the facility's records.

Class I

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

Based on interview, observation and record review, the Assisted Living Facility (ALF) failed to provide a safe and decent living environment, free from neglect for two of 40 sampled residents (Residents #20 and 25). Resident #20 after Staff C found the resident unresponsive and did not provide , , ( ) as instructed by a national training organization. The facility had 80 residents and several staff did not know procedures. The facility also did not have staff that spoke English, and staff were unable to assist an English-speaking resident when his , Resident #25, . Resident #25 subsequently was hospitalized and diagnosed with a pelvic . The facility failed to provide at least 45 days' notice of relocation or termination of residency from the facility when there was no medical reasons for one of 40 sampled residents (Resident #28). The facility used a wheelchair to prevent one of 40 sampled residents from exiting the bed unassisted by staff (Resident #1). The facility failed to treat residents with dignity by not providing privacy screen in

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where residents used bedside urinals.

The findings included:

1) A review of facility records showed Resident #20 on .

A review of the facility's policy/procedure regarding showed that staff were to perform on unresponsive residents, and continue until (Emergency Medical Services) arrived.

Staff C, interviewed on and gave the following accounts of her actions on :

a) On at 9:41 AM Staff C revealed, she found Resident #20 in his bed, unresponsive to verbal commands. Staff C immediately began to conduct on Resident #20. Staff stated she did not check for breathing or pulse, and only performed one cycle of 30 compressions to Resident #20. Staff stopped , and contacted 911 using her personal cell phone. Staff C stated the Emergency Medical Services ( ) operator told her either to continue chest compressions or use the Automated External Defibrillator ( ). She reported, she did neither because by the time she was about to go and get the , had arrived. She stated it took around ten (10) minutes for to arrive. After Staff C got off of the phone with 911, she yelled out for help and instructed another employee to wait for the ambulance in the front of the facility.

b) On at 9:04 AM, Staff C revealed, she worked from the 7 am to 3 PM shift. She further stated, residents usually went to the nurse's station to take their medication. Resident #20 was the only one who missed medications on . Staff went to Resident #20's check on him. Staff talked and moved the Resident but he was unresponsive. Staff stated, "I did 30 compressions, stopped, and called 911. Staff C reported, No, I did not call for help [from other staff]." Staff C revealed, she did not remember checking for a pulse or , . Staff informed the operator to hurry because the resident was becoming . Staff did not recall if the operator instructed her to do . The Operator instructed Staff C to go for the defibrillator. Staff left the resident alone and went to the next building for the defibrillator. On the way, staff instructed the rest of the staff to guide rescue staff to the residents .

Observation on at 9:29 AM revealed, the Automated External Defibrillator ( ) was in the nurse's station and it had a label of an expiration date on for the pads.

According to the American Association, an Automated External Defibrillator ( ) is a computerized medical device. It can check a person's rhythm and recognize if it requires an

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electrical . If the pads are expired, it does not attach to the skin and do the correct test.

Review of Staff C's record revealed staff C had completed First Aid, and Automated External Defibrillator training on .

In an interview on at 1:16 PM, Staff N revealed, she did not have training, but she was scheduled for a class next Wednesday.

During an interview on at 1:18 PM Staff L revealed, she worked in the facility for 5 years and had training. Staff L gave to someone who was unresponsive, not breathing, no good color. Staff L reported, she would give 5 breaths and 20 compressions (during the demonstration she demonstrated rubbing the chest for compressions) and reported someone else will come over and continue. If not, Staff needed to continue .

During an interview on at 1:26 PM, Staff O revealed, she had received training. Staff O stated, she thought she gave to someone with , problems, but she did not remember how.

In an interview on at 1:42 PM Staff C revealed, she had training. She reported, she gave to someone who was not reactive. She reported, she would put in a comfortable position, check for , and pulse. Staff C reported she would give 30 compressions and one breath; if no reaction, she would call 911.

During an interview on at 1:53 PM with the trainer who provided the class to the facility staff revealed, someone trained would give to a victim if the victim has shallow breathing, no pulse or a weak pulse, ensure the victim did not have . The American Association promotes the circulation as the most important system. The victim needed to be in a flat position or with a flat object in the back. A trained person needed to do 100-120 compressions per minute. Never leave the victim alone. If unable to call for help, , call 911. After every 30 compressions, give 2 breaths.

2) Staff who did not speak English were unable to assist an English speaking resident during an emergency.
Interview on with Resident #23 revealed, he found Resident # 25 on the floor on during the night. He reported, he went to the staff office, but none of the staff on duty spoke English, so he 'pantomimed' (used hand gestures) to tell staff about resident #25. Staff got upset with him because he had walked on the floor they just mopped, so they yelled and gestured at him. He didn't know what they

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were saying, but they seemed upset. He went to find some other residents to help pick Resident #25 up from the floor.

A review of resident #25's record revealed hospital discharge records which documented Resident #25 was hospitalized from to for a pubic rami . The resident arrived with left hip pain. An x-ray of the left hip showed a possible non-displaced of the left pubic /pelvis. The Pelvic CT completed on showed an acute, , non-displaced of the left medial pubic . An acute, non-displaced of the acetabulum with extension.

In an interview on at 10:31 AM via telephone Staff J revealed, she did not speak English, only Spanish.
In an interview on at 10:41 AM via telephone Staff K did not speak English, only Spanish.
In an interview on at 10:57 AM via telephone Staff B did not speak English, only Spanish.
In an interview on at 11:39 AM via telephone Staff D did not speak English, only Spanish.

In an interview on at 2:11 PM Resident #44 revealed, the only problem he has is that the employees do not speak English.

In an interview on at 2:21 PM Resident #23 revealed, the only problem he has is that the employees do not speak English.

In an interview on at 2:30 PM Resident #24 revealed, the only problem he has is that the employees do not speak English.

3) Resident #28 was moved to another facility without receiving a 45 day notice.

Review of Resident #28's record revealed an admission date of and a discharge date on . The health assessment dated on showed a medical history and diagnoses of Chronic , Incontinence, , (Hypertrophy) and Non - Valvular Vs (,)/Dyslipidemia. The resident ambulated independently without the use of an assistive device. The resident needed monitoring for medication compliance. Resident was not an elopement risk. The resident was independent for Activities of Daily Living and needed assistance with bathing. The resident had low fat/low diet and no communicable . The resident met criteria to live in the facility. The resident needed assistance with self-administration of medication.

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Record review of the observation log revealed, on at 8:30am, the staff was informed Resident #28 from the bed at 6:00am. The resident was getting up from bed, from the wrong side and slid off. Staff asked if the resident was okay and if he needed to go to the hospital, but he refused and went back to bed. The resident program was informed. On at 1:00 PM the following information was documented, "Today Resident #28 was discharged from the facility to Hospital. Resident was moved to them because is a small facility that way resident can receive more attention. Resident took with him all resident's belongings and all resident's medication. Resident's daughter was called but no answer, voicemail was left. Administrator was notified." There was no 45 days discharge notice in Resident #28's file and/or doctor notes that indicated that a higher level of care was needed.

4) Observation on at 8:30 AM revealed, Resident #1 was resting in bed in # with a wheelchair against the bed. The wheelchair blocked the resident from getting out of bed.

In an interview on at 8:30 AM Staff E stated, "I put a wheelchair against Resident #1's bed because the resident cannot come out from the bed by herself, therefore, this is how we prevent the resident from falling."

In an interview on at 2:30 PM the Administrator confirmed, Resident #1 did not have half-bed rails, and the facility did not have a management plan implemented for those residents who was at risk for .

5) Observations on at 8:15 am revealed there were urinals containing in 2, 12, 15, 17, 18,19, 20, 29, 23, and 24. There were no privacy screens in place. During an interview on around 9:00 am, the Administrator acknowledged there were no privacy screens.

During an interview with Resident #8 in on at 7:20 AM, the resident revealed he did not have a privacy screen to use the portable urinal unit.

Class I

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

Based on observation and interview, the facility failed to keep all medications in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times.

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Findings included:

On at 07:21 AM during the facility's tour, 1 prescribed and labeled and Cream usp 1 /0.05 (base) was found unlocked in # A; three prescribed and labeled bottles of Solution 10g/15 ml were found in a small refrigerator in # A.

During an interview on at 7:23 AM, Staff D acknowledged that the medications were unlocked.

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and interview, the facility failed to keep all Over The Counter (OTC) medications in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times.

Findings included:

On at 07:21 AM, unlabeled OTC medication, & flu, was found in shared # B.

During an interview on at 7:23 AM, Staff D acknowledged that the medication was unlocked.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, interview and record review, the facility failed to be under the supervision of an administrator who ensured the management of all staff and the provision of appropriate care to all residents, as required by Part II, Chapter 408, F.S., Part 2, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C. The administrator failed to ensure that staff were adequately equipped to provide needed care and services to residents. Several staff who were trained did not know how to provide , ( ), and one did not give to an unresponsive resident, who on (Resident # 20). The administrator and staff were unaware of residents who had . Six residents did not receive assistance in arranging for health care after hospitalizations for broken bones, and other conditions.

Findings:

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1) A review of the facility's policy/procedure regarding showed, staff were to perform on unresponsive residents, and continue until (Emergency Medical Services) arrived.

In an interview on at 9:41 AM Staff C revealed, that she found Resident #20 his bed unresponsive to verbal commands. Staff C immediately began to conduct on Resident #20. Staff C stated, she did not check for breathing or a pulse, and only performed one cycle of 30 compressions to Resident #20. Staff C stopped , and contacted 911 using her own personal cell phone. Staff C stated,the Emergency Medical Services ( ) operator told her either to continue or to use the Automated External Defibrillator ( ), but she did neither. It took around ten (10) minutes for emergency medical services to arrive.

Interviews with the 5 staff on duty on during the day shift found that 2 of them stated, they did not know how to perform , and the other 3 described an incorrect procedure which included a chest 'massage' instead of compressions.

Between and , the administrator took no corrective actions regarding the staff's inability to how they were required to perform . On , the Administrator said that she had spoken with all of the staff and they knew how to do , and that a retraining would be provided to all staff on . When reminded that the staff had not performed as trained, and when asked what would happen to residents who were found unresponsive prior to , the administrator stated that she would find a trainer to come in and provide updated training to one staff person on each shift , and that the entire staff would be retrained on . There was no documentation that the Administrator had attempted retraining or other interventions to ensure that unresponsive residents would be provided with before .

2) Observation of the facility's Automated External Defibrillator ( ) on at 9:29 AM revealed, the device was in the nurse's station and it had a label date of expiration of on the pads. According to the Administrator, the battery, recommended to be replaced annually, had never been replaced. According to the American Association an Automated External Defibrillator ( ) is a computerized medical device. It can check a person's rhythm and recognize if it requires an electric . If the pads are expired, they do not attach to skin and do the right testing and potential .

3) During an interview on at 1:39 PM the Administrator revealed, none of the 80 residents had a ( ). Four of five staff also stated that there were no residents in the

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facility who had a . One staff did not know what a was.

Record review found that there were 2 residents who had a . The administrator stated, the facility's policy was to identify residents who had a on admission, and that all staff were informed when residents had one. The administrator did not respond when she was asked why she didn't know that there were two residents who had a on file.

4) a. During an interview on at 11:36 AM Staff B stated, "Resident #2 is very independent and does not have any family members. Resident #2 does not have any wounds. Resident #2 walks just fine."

During an interview on at 11:46 AM Resident #2 stated, "My toe has been like that for a month, it hurts and pus is coming out. I told 5 people that I have it and it is getting worst and worst. I can't walk, when I put my left foot down, it hurts."

In an interview on at 11:50 AM the Administrator stated, "I did not know about it." Resident #2 saw a Podiatrist already, and I will call him again to see him."

During an interview on at 1:40 PM Resident #2 stated, "The toe hurts and it has secretions."

Interview and observation on at 1:42 PM revealed, Resident #2 pressed the right great toe and it drained fluid, but the surveyor was unable to see the color of the drainage because resident #2's three light switches and only one turned on and the light was dim. Resident #2 reported, he went to the doctor who made some cut in the toe, but it was worst. The resident reported, he has not received and the toe hurt when he walked, slept, and pressed the toe. The resident reported he hasn't seen any doctor recently.

During an interview on at 1:50 PM the Administrator revealed, the resident saw the podiatrist last month, but the facility staff did not have any report about the visit. The administrator reported the doctors did not give any report to the facility. It was revealed the resident already had an appointment for the next day with the podiatrist. At 2:02 PM on it was revealed, the resident started complaining about his toe about one week ago.

Review of Resident #2's record revealed, the resident had received care in the past. The communication log for home health revealed, the resident received care from to . The last entry was on and showed the had healed and the resident was discharged.

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The facility's progress notes for Resident #2 revealed:
On - The resident went to the podiatrist because the nail of the right toe hurt and the resident returned with a script (Prescription) for home health for a few days and they removed part of the toenail.
On - The resident had a toenail removed a couple of days ago but was doing just fine.
On - The resident's toenail was much better and almost fully recovered.
On - The resident's toenail was fully recovered.

Review of resident #2's record revealed, there was a doctor's order signed on for home health care to: clean with normal and apply triple to the area x 10 days.

Review of the facility's shift report showed:
On - On the 3-11 shift, resident #2 complained of pain in his toenail and on the 7-3 shift, Resident #2 was complaining of pain in his toe and staff called the podiatrist.

During an interview on at 2:35 PM with the Podiatrist office it was revealed, the Assisted Living Facility (ALF) staff scheduled resident #2's appointment on for the following day, on and the last time resident #2 was seen by the podiatrist was on , 2017.

Observation on at 2:21 PM revealed, resident #2's right great toe had a yellowish or cream color to the toenail area.

During an interview on at 9:15 AM with the License Practical Nurse (LPN) from the home health agency that provided care to Resident #2 revealed, the last time the resident received care was at the end of 2017.

Review of Resident #2's hospital record revealed, the resident arrived at the hospital on at 4:16PM and was admitted to the hospital at 9:15 PM. The emergency was an abscess of the first toe on the left foot. Review of the resident's bodily systems showed the resident had pain to the left big toe, it was and had a discharge. The physical exam noted the resident had pain and drainage under the left big toenail. The resident was alert, awake, and oriented to person, time and place. The resident's admission diagnoses included: left big toe and . An x-ray done on showed: no acute or . Joint space narrowing and varus deviation of the first MTP ( ) joint. The resident was started on every eight hours of - 3.375 gm and (apply to body surface) once a day of 2%.

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Record review revealed previously Resident #2 was admitted to the hospital on and discharged on . The resident was received in the emergency pain. The admission diagnoses were aneurysm and pain. The resident also had diagnoses of Cholelithiasis, ( ), Enlarged . The residents symptoms had started an hour prior and the resident had 4 episodes. The CT of the Abdomen and Pelvis without contrast showed, "significant aneurysmal dilatation of the which needs follow up to rule out any worsening or residual complication because of the patient's increased risk of risk for perforation. cannot be rule out on the non-contrast study".

Review of Resident #2's Health assessment (AHCA form 1823) completed on revealed, the residents medical history and diagnoses included ( ) and ( ). Physical or sensory limitations: ambulates with a cane. or behavioral status: none. The resident was independent for all activities of daily living except for self-care and needed supervision. The resident needed assistance with self-administration of medications.

Review of resident #2's record revealed, there were discharge instructions from the hospitalization. The residents discharge diagnosis was AAA (Aneurysm) and pain. The follow up instructions required to follow up with the residents primary care physician (PCP) within 5-7 days. There was no documentation that Resident #2 received follow up care with the PCP.

During an interview on at 12:41 PM the Administrator reported, there was no documentation about a doctor seeing the resident. She further stated, staff called the doctor, who recommended to 'just to check the resident's and ensure it was under regular parameters.' A review of the staff personnel files revealed, none of the staff were a licensed health care provider.

b) Resident #16 had a hip and had no documented assistance from staff in obtaining follow-up care with the PCP.

On at 12:58 PM Resident #16 stated, "The floor was wet, and I . It was the first time I , I was in the hospital for about two months.

On at 1:00 PM the Administrator confirmed, Resident #16 was hospitalized for a and had surgery for a broken hip. The Administrator also stated that she had no documentation and/or written

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information about the residents broken hip. The Administrator stated, "Resident #16 is not walking with the assistance of the cane because he is afraid and he is refusing to walk. The doctors told me that he is doing well. I have no documentation that reflected he could walk and/or he is doing well."

c) Resident #21 was and was hospitalized six times in the last four months. Three of the six hospitalizations were for low sugar level.

Review of Resident #21's record showed that admission date was on . Health assessment (AHCA form 1823) completed on and showed a medical history and diagnoses: left above the knee amputation, ( ), ( ), HBP (High), type 2 (Type 2), ( ), Parkinson. or behavioral status: depressed and . Nursing/ treatment/ service requirement: supervise medications. Special precautions: precautions. The resident was independent for ambulation, eating, toileting, and transferring, needed supervision for self-care and assistance for bathing and dressing. The resident had a regular diet. The individual's needs could be met in and ALF. Resident needed assistance with self-administration of medication.

Review of Resident #21's facility progress notes revealed:
On - Resident observed to be having hallucinations.
On - Resident returned from hospital with discharge documents and scripts (prescription) sent to pharmacy.
On - A resident went to the office and informed staff a resident was sitting outside a was drooling. Staff found the resident drooling and unresponsive. Staff called 911 and transferred the resident to the hospital.
On - Resident #21 returned from the hospital with discharge papers, but no scripts.
On - Resident #21 complained of not feeling well. The resident had . The medical doctor (MD) was called to evaluate the resident. The Resident was transferred to the hospital.
On - The resident returned from the hospital with discharge papers and scripts sent to the pharmacy.
On - The night shift reported to the morning shift, staff saw the resident was unresponsive. Staff called 911 and transferred the resident to the hospital at 5:30 AM.
On - The resident returned from the hospital with discharge papers but no scripts.
On - The resident's went to the office and informed the staff the resident was screaming and making several hand movements. The staff found the resident laying in bed screaming, but staff weren't able to understand the resident. The rescue staff/911 staff was called and transferred the resident to the hospital. The residents friend was notified.

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On - The resident returned from the hospital and brought discharge papers with him.
On - The resident started to receive home health services for sugar monitoring.
On - The progress notes did not show the Resident saw the Primary Care Physician after the hospitalization.
On at 3:50 PM - The resident's went to staff and reported Resident #21 was not acting right. Staff went to the saw Resident #21 foaming from mouth and unresponsive. Staff called 911 and rescue staff took the resident to the hospital.

In an interview on at 11:16 AM with the Administrator it was stated, "We sent resident #21 to the hospital, informed the doctor, and asked the doctor to follow up. The supervisor was responsible to review the record, do the changes and follow up. The supervisor was responsible to inform the doctor. It is pretty much from the same thing Resident #21 has been going out.

In an interview on at 11:29 AM, the Administrator revealed, the Supervisor was new, and said 'Staff F missed it.'

Resident #21 was taking 500 mg twice a day and , 2 mg daily for management.

In an interview on at 11:38 AM with the facility administrator, about knowing whether the resident had any changes prior to the hospitalization on , the Administrator stated, "if it is not documented I don't know." At 11:43AM the Administrator revealed, the resident received home health services for sugar monitoring, but insurance approved the monitoring for twice a week.

d) Resident #23, health assessment dated shows diagnoses of , , , gait disturbance, hypertensive . Was assaulted by his Resident #25 on . His eye was , and he went to the hospital, was treated for an eye injury and fitted with an eye patch. There was no documentation of follow up with a medical provider found in the facility's records. Resident #25 was moved to another his hospitalization, but there was no documentation of Resident #23 receiving assistance regarding the assault.

e) Resident #25 out of bed at the facility and had a of left the medial pubic /pelvis. There was no documentation that the resident received follow up care with the primary care physician (PCP) after the resident returned to the facility after the hospitalization.

f) Review of Resident #33's Medication Observation Record (MOR) revealed on , , , , , , , , and refused 20

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mg (an medicine). Resident refused (a and) 50 mg on , and . The Resident refused (a medicine for on and . In an interview on at 1:25 PM the Administrator revealed, Staff should be calling the doctor and documenting in the progress notes. A review of Resident #33's progress notes showed that there was no documentation of the medication refusals or of any intervention or coordination with health care providers.

Class I

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, interview and record review, the facility failed to ensure that individuals providing services were qualified to perform their assigned duties. Staff C, who was trained in , , , ( ), failed to provide continuous to an unresponsive resident until help arrived, as was outlined in the training and in the facility's policies and procedures. Resident #20 on .

The findings included:

A review of facility records showed Resident #20 on .

A review of the facility's policy/procedure regarding showed that staff were to perform on unresponsive residents, and continue until (Emergency Medical Services) arrived. The policy stated: 1. In case a resident is found unresponsive, the staff member will contact 911 and provide resident with until rescue personnel arrives at facility. 2. The Administrator, if not present at the time should be immediately contacted as well. 3. The paramedics will determine if resident is in need of acute care, or if resident has in fact expired. 4. In the event that paramedics determine and officially declare the resident as having expired, they should contact the local police department who will fill a report. 5. The police department will notify the resident's responsible party, representative (sponsor) or emergency contact, and physician. 6. The Administrator will also contact all parties involved to confirm information and arrange for a convenient time for resident's belongings to be retrieved from facility.'

Staff C, interviewed on and gave the following accounts of her actions on :

a) On at 9:41 AM Staff C revealed, she found Resident #20 in his bed, unresponsive to verbal

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commands. Staff C immediately began to conduct on Resident #20. Staff stated she did not check for breathing or pulse, and only performed one cycle of 30 compressions to Resident #20. Staff stopped , and contacted 911 using her personal cell phone. Staff C stated the Emergency Medical Services ( ) operator told her either to continue chest compressions or use the Automated External Defibrillator ( ). She reported, she did neither because by the time she was about to go and get the , had arrived. She stated it took around ten (10) minutes for to arrive. After Staff C got off of the phone with 911, she yelled out for help and instructed another employee to wait for the ambulance in the front of the facility.

b) On at 9:04 AM, Staff C revealed, she worked from the 7 am to 3 PM shift. She further stated, residents usually went to the nurse's station to take their medication. Resident #20 was the only one who missed medications on . Staff went to Resident #20's check on him. Staff talked and moved the Resident but he was unresponsive. Staff stated, "I did 30 compressions, stopped, and called 911. Staff C reported, No, I did not call for help [from other staff]." Staff C revealed, she did not remember checking for a pulse or . Staff informed the operator to hurry because the resident was becoming . Staff did not recall if the operator instructed her to do . The Operator instructed Staff C to go for the defibrillator. Staff left the resident alone and went to the next building for the defibrillator. On the way, staff instructed the rest of the staff to guide rescue staff to the residents .

Observation on at 9:29 AM revealed, the Automated External Defibrillator ( ) was in the nurse's station and it had a label of an expiration date on for the pads.

According to the American Association, an Automated External Defibrillator ( ) is a computerized medical device. It can check a person's rhythm and recognize if it requires an electrical . If the pads are expired, it does not attach to the skin and do the correct test.

Review of Staff C's record revealed staff C had completed First Aid, , and Automated External Defibrillator training on .

In an interview on at 1:16 PM, Staff N revealed, she did not have training, but she was scheduled for a class next Wednesday.

During an interview on at 1:18 PM Staff L revealed, she worked in the facility for 5 years and had training. Staff L gave to someone who was unresponsive, not breathing, no good color. Staff L reported, she would give 5 breaths and 20 compressions (during the demonstration she demonstrated rubbing the chest for compressions) and reported someone else will come over and

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continue. If not, Staff needed to continue .

During an interview on at 1:26 PM, Staff O revealed, she had received training. Staff O stated, she thought she gave to someone with problems, but she did not remember how.

In an interview on at 1:42 PM Staff C revealed, she had training. She reported, she gave to someone who was not reactive. She reported, she would put in a comfortable position, check for and pulse. Staff C reported she would give 30 compressions and one breath; if no reaction, she would call 911.

During an interview on at 1:53 PM with the trainer who provided the class to the facility staff revealed, someone trained would give to a victim if the victim has shallow breathing, no pulse or a weak pulse, ensure the victim did not have . The American Association promotes the circulation as the most important system. The victim needed to be in a flat position or with a flat object in the back. A trained person needed to do 100-120 compressions per minute. Never leave the victim alone. If unable to call for help, call 911. After every 30 compressions, give 2 breaths.

Class I

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on record review and interview, the provider failed to have a surety bond with the minimum bond proceeds that equal twice the value of the residents' monthly aggregate income for residents.

Findings included:

Record review revealed that the facility did not have proof of a surety bond with a minimum bond that equal twice the value of the residents ' monthly aggregate income in the facility at time of survey.

Record review revealed that the facility had copies of the checks that received monthly to the account, and it reflected $9,907.00. The facility provided a surety bond for $10,000.00 dated from - , instead of for the minimun $19,814.00 required.

Interview on at 1:00 revealed Staff A stated, "The facility had a surety bond." In addition, Staff A

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953384	03/07/2018
NAME OF PROVIDER OR SUPPLIER **COURTYARD MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **140 W 28 STREET** **HIALEAH, FL 33010**	

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

acknowledged that the facility's surety bond was for $10,000.00.

Class III

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

Based on record review and interview, the facility failed to have an accurate health assessment for three of 10 sampled residents (#1, #12, #24 and #31). The facility also failed to have an accurate background screening result on file for one out of 13 sampled staff (Staff E).

Findings included:

Observation on at 12:00 PM revealed that Staff E assisted Resident #1 to transfer from the bed to the wheelchair.

Record review revealed that Resident #1 had a health assessment dated on that stated, " , Anorexia Chronic, , and . Resident #1 needs wheelchair and independent transferring.

Record review revealed that Resident #1's Admission weight reflected as 160 pounds on . Resident #1's health assessment weight reflected as 130 pounds on . In addition, Resident #1's weight information log stated, "From - Resident #1 has no weight information due to wheelchair (W/C).

Interview on at 12:00 PM Staff E states, "We are not weighting Resident #1 because we have no machine for people that used wheelchair." Interview at 2:00 PM Staff A confirmed that Resident #1 had no weight record due to Resident #1 used wheelchair."

Record review revealed that Resident #31's (admitted) home health book had administration information. Resident #31 had an 's order dated on . Resident #31's health assessment dated on stated, "Needs administration of medication." However, Resident #31's health assessment did not reflect that he was under administration.

A review of Residents #12 and #13' files on revealed that Resident #12's health assessment dated and Resident #24's health assessment dated stated "Needs assistance with self-administration of medications" while both Residents are receiving from Home Health Services.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

During the exit interview on at 3:07 PM, Staff B acknowledged the health assessment of Residents #1, #12, #24 and #31 were not accurate.

2)

Review of the facility's file on revealed that Staff E hired on 11/ did not have an updated printed background screening result in file. The screening result found in file was expired and dated . Background Screening Clearing house reviewed on revealed that Staff E's last screening was completed on .

During the exit interview on at 3:07 PM, Staff B acknowledged that Staff E did not have an accurate and printed background screening result, but did not state the reason why Staff E did not have it on file.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview, the facility failed to provide a contract containing the monthly rates to be paid for three of 10 sampled residents (#2, #31 and #32).

Findings included:

A review of Resident #2's file on revealed that Resident #2's contract signed on did not have the monthly rate being paid reflected on the contract.

Record review revealed that Resident #31 signed the facility contract on ; however, there was no monthly rate reflected.

Record review revealed that Resident #32 signed the facility contract on ; however, there was no monthly rate reflected.

During the interview on at 11:36 AM, Staff B stated, "Resident #2 signed the contract himself."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953384	**03/07/2018**
NAME OF PROVIDER OR SUPPLIER **COURTYARD MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **140 W 28 STREET HIALEAH, FL 33010**	

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

On at 1:00 pm Staff A stated, "I knew that I have to put the monthly rate for those residents, I postponed to sign them day by day, and I forget to do it; we have eighty residents; it is a lot to do."

Class III

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

Based on record review and interview, the facility failed to provide a minimum of 8 hours of specialized training in working with individuals with mental health diagnoses to one of 13 sampled staff (Staff F and M).

Findings included:

Observation on at 7:00 am revealed that Staff F worked in the facility assisting residents. Further observation on at 6:48 am revealed that Staff M worked in the facility assisting residents, too.

Record review revealed that Staff F provided direct care for the facility residents. There was no documentation that Staff F, hired on , had received a minimum of 8 hours of Limited Mental Health (LMH) training.

Record review revealed that Staff M provided direct care for the facility residents. There was no documentation that Staff M, hired on , had received a minimum of 8 hours of Limited Mental Health (LMH) training in file.

During the exit interview on at 3:07 PM, Staff B acknowledged that Staff F did not have a LMH certificate.

Interview on at 6:50 am Staff M stated, "I worked with Staff M; he is my co-worker during 11:00 pm - 7:00 pm."

Class III