

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ824 SS=C	408.811 FS; 59A-35.120 FAC Right of Inspection; Inspection Reports 408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.- (1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application. (a) All inspections shall be unannounced, except as specified in s. 408.806. (b) Inspections for relicensure shall be conducted biennially unless otherwise specified by authorizing statutes or applicable rules. (2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification. (3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an	CZ824		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
CZ824	Continued From page 1 offsite review. (4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency. (5) The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required. (6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership. (b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection. 59A-35.120 Inspections. (1) When regulatory violations are identified by the Agency: (a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency	CZ824			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ824	Continued From page 2 notice to the provider, unless an alternative timeframe is required or approved by the Agency . (b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time. (2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency. (3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide: (a) Documentation from the accrediting agency including the name of the accrediting agency, the beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation. (b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide documentation of personnel records for one out of seven sampled staff members (Staff D). Findings included:	CZ824			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA		STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
CZ824	Continued From page 3 On at approximately 6:45 pm, upon request for Staff D's personnel records, Staff F stated that Staff D's personnel records were stored under lock and key in the administrator's office and she did not have the key to open the office. On at approximately 6:50 pm, observed the administrator's office was locked. Unclassified	CZ824			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Three complaint investigations (complaint numbers 2019012082, 2019008029, and 2019007877) were conducted at Livewell at Courtyard Plaza on _____ through _____. Deficiencies were identified at the time of survey.	A 000		
A 025 SS=G	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 1 resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a general awareness of the whereabouts of two of 10 sampled residents (Residents 2 and 3). Resident 2 eloped and never went . . . to the facility. Resident 3 eloped from the facility, was found and discharged on the same day. Findings included: Review of Resident 2's record showed admission , last health assessment dated , No known Diagnosis: , impulse control , , unspecified right , , closed reduction and intramedullary nailing. Not an elopement risk. Stable. Medication assistance needed. Independent with all daily activities. Mechanical soft diet with ground meats. Documentation for -Resident discharged from facility. Discharge to self. Resident signed out and informed of medications and any future	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 2 On 8/27/2019 at 3:37 PM, Resident 2's family member stated that Resident 2 was not discharged from the facility. She stated that the facility told her that they took the residents out shopping for an activity and that he left at that time. The family member stated that he never returned to the facility to retrieve any items of clothing, medications, or any of his things and that she has not seen him and is not sure where he is. She stated that he texted her twice that same week that he left but did not answer him because she was upset that he just left. On 8/27/2019 at 3:33 PM, Resident 2 stated during a phone conversation that he left on his own during an outing. The resident stated that he came to the facility from the hospital due to broken bones resulted from a fall. He stated that the facility was like a jail, and that the place was not for him, that the people at the facility were always loud, crying and talking to themselves and that he preferred to be on the streets and that is where he has been since he left. He stated that he was supposed to have six months to recuperate, receive physical therapy, and see a doctor to follow up on his condition and that the facility did not do any of that. He concluded that he walked on his own and got himself in good condition and that they only gave him government medical services for 2 months so he could not see the doctor and repeated that he was Ok, and that the facility was not for regular people and it was not the place for him. On 8/27/2019 at 5:30 PM during a phone call interview Resident 2 stated, "I could not live there anymore, I am mentally Ok, I just had an accident and was supposed to be there	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 3 temporary for treatment; they gave me the benefits for only 2 months, and they took them from me. The day I did not return, I took advantage that they were going to the store and immediately when we arrived, I took a bus that was going to Downtown Miami. I never went . . . , and I am living on the streets again; one of the nurse assistants called me on that day and I told her, I was not coming I am taking my medications; I have managed to get them by other sources. In that facility, they were giving me the medications wrong; there was a medication that I was supposed to get only at bedtime, and they were giving it to me also during the morning; they think I am stupid, but I know what they were doing." Review of Resident 3's records showed admission Last health assessment with a diagnoses of . . . type II, . . . , high prostatic hyperplasia and Physical limitations: Generalized No special precautions. Elopement risks. Independent in all activities of daily living, except for assistance with ambulation, utilizing rolling walker. A 45-day notice document with a title of "Temporary Care Program for Hospital Residents" showed signed by the resident on the day of his admission, A first health assessment for the resident was not available at the facility. On , the administrator stated not to know where the health assessment was. A review of Resident #3's records showed: at 9:00 PM. Resident left facility in the morning and did not return by 8:00 PM. At 2:00	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA		STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 025	Continued From page 4 AM, a phone call from a gas station employee stated that resident was in the gas station's bathroom drunk and on the floor. The employee stated that the resident purchased beer and then went into the bathroom and was in there for 2 hours. The facility staff drove to the gas station and found the resident very drunk on the floor. The staff brought him to the facility. The incident was reported to the hospital. Action taken: The resident was re-educated on rules of the facility and the risks of drinking while taking all medications that he has been prescribed. Follow up needed on a daily monitoring. Resident was observed returning to facility and was found with a 40 oz. of beer and appeared intoxicated. Resident was informed that he is only allowed to go on bus trips with supervision of the activity coordinator or we will provide transportation to wherever he needs to go. Resident informed that can go to bus trips. 8:30 AM, Resident was seen by staff, eloping from facility at 8:30 AM. Resident waited until receptionist stepped away from front, went behind desk, press button to let himself out. Resident stated he was in , but already had medication in building. Resident was found across the street in the street. Resident brought into building by intake coordinator. Resident now deemed an elopement risk as change in behavior. Resident now allowed out unless accompanied by staff. Daily monitoring needed. 2:00 PM, Resident was observed exit seeking today. When staff approach him for re-direction, he became physically and verbally aggressive. Resident returned to behavioral	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 025	Continued From page 5 hospital for another placement. Resident discharged. A review of Resident 3's elopement risk assessment for _____ showed a score of 8 which is greater than number 5 and the facility proceeds with elopement precautions: A - Apply facility/resident name identification bracelet. B - Involve in activities, especially during periods of restlessness. C - Redirect efforts to elope. D - Include resident identification, _____ sheet, and a copy of this elopement assessment tool in the elopement log located at the reception desk. A review of the facility's Elopement Policy and Procedures showed procedures: When it is suspected that a resident is missing; a missing resident alert will be announced to all staff in the building and immediate search must be conducted of the facility and premises; notify the administrator. Missing resident process: To be implemented by the administrator and or manager / supervisor on duty. Time frame should not exceed 20 minutes. If the facility staff search fail to locate the resident, staff must notify the following: All family listed in the resident file, the resident's health care provider. Staff must conduct an immediate search of the neighborhood either by _____ or by car checking parked cars, bushes, walking paths, alongside the roadways, bus stops. The police must be notified if the immediate search does not provide results. Administrator will provide an initial 1-day report online to the agency for health care administration adverse incident reporting system and will complete a full adverse reporting online before the 15th day of the elopement. A review of Resident 3's records showed an	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 6 elopement risk assessment dated ... with a final score of 8 of 15 and stating that a score of 5 or greater, the facility should proceed with elopement precautions: Apply facility/resident name identification bracelet. Involve in activities, specially during periods of restlessness. Redirect efforts to elope. Include resident identification, ... sheet, and a copy of this elopement assessment tool in the elopement log located at the reception desk. On ... at 4:21 pm, the Administrator stated, "Residents have to sign in and out of the facility if not, the residents will be considered an elopement risk." Review of the adverse incident reports showed none for Residents 2 or 3. Class II	A 025		
A 030 SS=D	58A-5.0182(6) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 7 complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96- _____ or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. _____ and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident _____, neglect, and _____; 6. Administrative and housekeeping schedules and requirements; 7. _____ control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8 sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9 personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10 for health care services, the provision of or arrangement of transportation to health care services, and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ill, the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 11 telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27(1)(a), FS Property and personal affairs of residents. - (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 12 which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that two out of three sampled residents (Resident #11, Resident #3) were given a 45-day notice of discharge prior to being discharged. Findings included: 1) Record review showed that Resident #11 was discharged on _____ after being sent to the hospital for an evaluation on _____. Resident #11 progress notes documented the resident was observed in the courtyard with no problem on _____. On _____, the facility sent the resident to hospital for an evaluation. On _____, the facility discharged the resident to the hospital. On _____, the facility contacted the resident's primary contact to inform that the hospital would be placing the resident in a Skilled Nursing Facility (SNF). The facility did not have documentation to show that the resident needed a higher level of care. 2) Record review showed that Resident #3 was discharged from the facility on _____. The facility documented on _____ that Resident #3 was observed returning to the facility with a 40 oz. container of beer and appeared intoxicated. The record further stated that Resident #3 was informed that the facility would only allow the resident to go on bus trips with supervision of the activity coordinator, and that the facility would	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 13 provide transportation. The record stated that on Resident #3 eloped and was identified as an elopement risk. On _____ the facility further documented that Resident #3 tried to exit the facility. Staff were called and redirected the resident. The record stated Resident #3 was physically and verbally aggressive toward the staff. On _____, the facility discharged Resident #3 to behavioral hospital. The facility did not have documentation that a 45-day notice of discharge was given to Resident #3 or that the resident required a higher level of care. On _____ at 03:15 pm, Staff A stated that the facility had a contract with a specific hospital which stated that they could discharge a resident referred by that hospital under this contract, if the resident did not return to the facility within 24 hours after leaving the facility. Class III	A 030		
A 052 SS=D	429.256() ; 58A-5.0185 (3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an _____ syringe that is prefilled with the proper dosage by a pharmacist and an _____ that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 052	Continued From page 14 (c) Placing an oral dosage in the resident's _____ or placing the dosage in another container and helping the resident by lifting the container to his or her _____. (d) Applying _____ medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a _____, including removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (h) Using a _____ to perform _____ level checks. (i) Assisting with putting on and taking off _____ stockings. (j) Assisting with applying and removing an _____ but not with titrating the prescribed _____ settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with _____ bags. (4) Assistance with self-administration does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 052	Continued From page 15 inserted in a _____ of the body. (d) Administration of _____ preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) _____ or _____ preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. 58A-5.0185 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self administered medication pursuant to the training requirements of rule 58A-5.0191, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups,	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 052	Continued From page 16 and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 052	Continued From page 17 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that staff followed the procedures described in section 429.256, F.S. while assisting residents with self-administered medications for one out of 30 sampled residents (Resident # 28). The staff provided twice the same medication to Resident # 28. Findings included: On at approximately 4:30 pm, Staff D assisted Resident # 28 with self-administration with medication. Staff D dispensed a softgel capsule from a prescribed bottle labeled 'Reno Caps Softgel' into a small white cup but she informed the resident that was going to take "....." instead of Reno Caps. The resident swallowed the medication and then Staff D initialed the Medication Observation Record (MOR) next to the medication label 325mg Tablet. On at 6:20 PM, Staff D stated, "No one told me and Reno Caps aren't the same. I thought it was the same". On at 6:54 PM, Staff D used a medication cart which had in the first drawer a bottle of "Iron 65 mg equivalent 325 mg".	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 052	Continued From page 18 On _____ at 7:11 PM, Staff G revealed that she was a Licensed Practical Nurse (LPN). At 7:16 PM, she added that _____ was not the same as Reno Caps. According to WebMD, overdosing on Reno Caps Softgel can cause symptoms such as _____ and/or _____. Class III	A 052			
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known _____ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 054	Continued From page 19 is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical _____, the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to immediately update the Medication Observation Records (MOR) each time the medication is offered when assisting one out of 28 (Resident # 10) sampled residents. Staff D erroneously initiated the wrong medication when given a completely different medication to Resident # 28. The facility also failed to have any documentation when 'as needed' medications were given. Findings included: 1) On _____ at approximately 4:30 pm, observed Staff D conduct medpass to Resident # 28. Staff D used _____ sanitizer before taking out a prescribed bottle labeled 'Reno Caps Softgel'. Staff D then read the medication label as " _____" to Resident # 28 and placed one softgel of Reno Caps onto the bottle cap and then onto a small white cup. Staff D then handed Resident # 28 the white cup and observed the resident swallow the medication with a cup of water. A review of Resident # 28's MOR revealed that Staff D initiated the MOR as if the resident was given the medication _____ 325mg Tablet.	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 20 On at 6:20 PM, Staff D stated "No one told me and Reno Caps are the same. I thought it was the same". 2) A review of Resident # 10's MOR revealed all morning medications were initiated on except for D3 2,000 Unit Tablet. A medication reconciliation of the medication D3 2,000 Unit Tablet revealed one tablet was missing from the medication pack dated 3) On at 6:01 PM, Resident #28's medications were reconciled and showed the following medications missing: - 25 mg tablet had instructions to chew one tablet by every day for 10 days as needed for The pharmacy dispensed the medication on and had eight tablets left. - 800 mg tab had instructions to take one tablet by two times a day. The pharmacy dispensed 30 tablets of the medication on The medication bottle was labeled "P.R.N." (as needed) and the bottle had 17 tablets left a month later on A review of Resident # 28's MOR revealed the following: - A doctor's order for 25mg tablet with instructions to take one table by once daily and scheduled to be taken at 8AM. However, there was a change in orders from the doctor that changed 25mg tablet once	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 054	Continued From page 21 daily to a 'PRN' (as needed) medication on . The new prescription showed the instructions to take . 25mg tablet (10 tablets) to take 1 tablet by . daily as needed for . There was no documentation that staff initiated the . part of the MOR for the . ordered or documented the reason(s) for taking the medication. - A doctor's order for the months of . and . for . 800 mg tablet with instructions to take one tablet by . twice daily as needed for . maximum of two tablets in 24 hours. There was no documentation that staff initiated the . part of the MOR for the . ordered or documented the reason(s) on why the resident had to take the medication throughout the two months. Review of progress notes in Resident #28's record showed that the facility completed progress notes on . and . However, none of the progress notes showed that the resident complained about . or that the resident has been prescribed a medication for . On . at 5:06 PM, the Staff E revealed that she follows the order for giving 'as needed' medications to a resident. On . at 6:14 PM, Staff D explained that when a resident needs a medication ordered as needed for ., she would first call the nurse (Staff G). Then, she would ask the nurse for instructions before giving the dose and then give the medication as instructed by Staff G. Staff D then stated that she would document the . of the MOR and would check the resident within one	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA		STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 054	Continued From page 22 to two hours later for results. Staff D also explained that if the resident was still in , she would then inform the nurse to see if the resident would have to be sent to the hospital. Staff D revealed that she was not a licensed registered nurse. At 6:21 PM, she also revealed that when a staff needs to discard a medication, another staff would have to witness the medication being flushed down the toilet, then have it documented in the MOR. On at 7:18 PM, Staff G explained that staff signed the 'as needed' medication in the of the MOR and when a medication is discarded, it had to be documented in the MOR. Class III	A 054			
A 055 SS=D	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 055	Continued From page 23 being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 58A-5.0181, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future	A 055		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 055	Continued From page 24 use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may be disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to keep medication locked at all times. Findings: On _____, at 3:15 pm, observed a small pill on the floor in the smaller dining room behind the double doors inside the larger dining room. On _____, at 3:19 pm, the Administrator	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 055	Continued From page 25 acknowledged the pill on the floor and stated that the room had not been used in 2 years. The Administrator stated that the pill likely rolled under the door. On _____, at 3: 22 pm, Staff E came into the small dining area. Staff E retrieved the medication and stated that she would discard the medications. Staff E stated that she ensured that all her nurses closely monitored the medications. Staff E stated that she did not know what medication it was or who it belonged to. Class III	A 055			
A 056 SS=G	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 056	Continued From page 26 directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for . . . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxed, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 056	Continued From page 27 rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to contact the healthcare provider and request revised instructions for the ordered medications used 'as needed' for five out of 28 sampled residents (Resident # 6, # 7, # 9, and # 29). The facility also failed to maintain an accurate amount of medications for two out of 30 sampled residents (Resident #28 and # 29). More medication was missing than should have been, based on the date prescriptions were filled, and there was no documentation that the residents received the medications.	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 056	Continued From page 28 Findings included: 1) A review of Resident # 6's Medication Observation Record (MOR) revealed Resident # 6 was prescribed 2 mg Tab with instructions to 'Take 1 tablet by ... 3 times daily as needed'. In addition, Resident # 6 was also prescribed ... 500 mg Tab with instructions to 'Take 1 tablet by ... 2 times a day as needed'. Neither of the instructions stated the circumstances under which it would be appropriate for the resident to request the medication. There was also no documentation on a maximum dosage the resident can take in a 24-hour window. A review of Resident # 7's MOR revealed Resident # 7 was prescribed Loratidine 10 mg Tab with instructions to 'Take 1 Tablet by once daily as needed'. There was no documentation of instructions stating the circumstances under which it would be appropriate for the resident to request the medication. There was also no documentation on a maximum dosage the resident can take in a 24-hour window. A review of Resident # 9's MOR revealed Resident # 9 was prescribed 10 gm/15 ml Solu with instructions to 'Take 30 ml by ... daily as needed', and 4 mg Tab with instructions to 'Take 1 tablet by ... every 6 hours as needed'. Neither of the instructions stated the circumstances under which it would be appropriate for the resident to request the medication. There was also no documentation on a maximum dosage the resident can take in a 24-hour window.	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 056	Continued From page 29 A review of Resident # 29's MOR revealed Resident # 29 was prescribed Celebrax 200 mg Capsule with instructions to "Take 1 Capsule by daily as needed". There was no documentation of instructions stating the circumstances under which it would be appropriate for the resident to request the medication. There was also no documentation on a maximum dosage the resident can take in a 24-hour window. On at 1:27 pm, Staff C stated "If the resident here feels like they have , or any symptom, they have to come and ask me and I'll check their orders to see if they have the order for as necessary order , . If the patient first refuses a medication, I'll let the DON know". DON stands for Director of Nursing. On at 6:20 pm, Staff D stated "we give it when the residents asks for it. I know if it's for , , we always ask the DON". She also stated that she would talk to the DON and receive her instructions and give the medication to the resident and document the time/date on the . . . of the MOR and reassess the resident after an hour or two. 2) On at 6:54 PM, Resident #29's medications were reconciled and showed the following: - A medication card for , 200 mg capsule with instructions to take one capsule by three times daily and labeled as a bedtime medication. The pharmacy had dispensed 87 capsules of the medication on and the capsules were divided into three different . . . cards. The bedtime pack had 10 capsules	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 056	Continued From page 30 left. - A second medication card for Fum 400 mg tablet with instructions to take two tablets by at bedtime. The pharmacy had dispensed 58 tablets of the medication on and there were 20 tablets left. - A third medication card for 20 mg tablet with instructions to take one tablet by daily at 9 PM. The pharmacy had dispensed 29 tablets of the medication on and there were 10 tablets left. Review of Resident # 29's MORs showed a doctor's order for 50 mg tablet with instructions to take two tablets (100 mg) by four times daily as needed for non-acute , maximum four doses per day. The staff had initiated the MORs four times daily from to and on three times. The staff documented the of the MOR each time the was given; however, there was no documentation about the doctor being informed that the resident had been taking four times daily on regular basis. According to Drugs.com, the medication carries a warning on how exposes patients and other users to the risk of , addiction, , and misuse, which can lead to overdose and . More common side effects on taking frequently include, , , discouragement, drowsiness, feeling or empty, , , etc. Class II	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 31	A 165		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident 's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2019
NAME OF PROVIDER OR SUPPLIER LIVEWELL AT COURTYARD PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 165	Continued From page 32 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) . . . , neglect, or . . . must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 33 by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to report adverse incidents of events regarding resident who left the facility without staff knowledge within one business day and fifteen days for 2 out of 28 residents, (Residents 2 and 3). Findings: A review of the incident report database did not show an adverse incident report for Residents 2, 3 and 4. 1. Record Review showed in the observation	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 34 notes that on [redacted], Resident 2 was discharged from facility. Another note dated [redacted] stated that the resident had been 'discharged to self', and that Resident 2 signed out and was informed of the medications and of any future [redacted]. On [redacted], at 3:37 PM, the resident's family member stated during a telephone interview that Resident 2 was not discharged from the facility. The family member stated that the facility told her that they took the residents out shopping for an activity, and Resident 2 left at that time. The family member stated that Resident 2 never returned to the facility to retrieve any items of clothing, medications, or any of his things. On [redacted], at 3:33 pm, Resident 2 stated during a telephone interview that he left during an outing and never returned. 2. A review of Resident 3's record showed admission [redacted]. The last health assessment date [redacted] showed diagnoses of [redacted] Type II, [redacted] [redacted] prostatic hyperplasia, [redacted] Generalized [redacted]. The resident was identified as an elopement risk. He needed assistance with ambulation (utilized a rolling walker), and was independent with all other activities of daily living. Observation notes on [redacted] showed: 'Resident observed having breakfast and conversing, no concerns. [redacted] - Resident discharged from facility. Resident sent [redacted] to Jackson for evaluation and discharged.' Observation notes on [redacted] showed: 'Resident was observed returning to facility and was found with a 40 oz. of beer and appeared	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVEWELL AT COURTYARD PLAZA

**15520 NW 2 AVENUE
NORTH MIAMI BEACH, FL 33160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 35 intoxicated. Resident was informed that he is only allowed to go on bus trips with supervision of the activity coordinator or we will provide transportation to wherever he needs to go. Resident informed that can go to bus trips.' Observation notes on showed 8:30 AM. Resident was seen by staff, eloping from facility at 8:30 AM. Resident waited until receptionist stepped away from front, went behind desk, press button to let himself out. Resident stated he was in . . . but already had . . . medication in building. Resident was found across the street . . . in the street. Resident brought . . . into building by intake coordinator. Resident now deemed an elopement risk as change in behavior. Resident now allowed out unless accompanied by staff. Daily monitoring needed.' Observation notes on showed '2:00 PM. Resident was observed exit seeking today. When staff approach him for re-direction, he became physically and verbally aggressive. Resident return to behavioral hospital for another placement. Resident discharged.' Review of Resident 3's elopement risk assessment for showed a score of 8 which is greater than number 5. According to the facility's procedures, the facility proceeds with elopement precautions in this circumstance. Class III	A 165		