Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967753	A. BUILDING: _____ B. WING _____	R 01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA'S DEDICATED RETIREMENT HOME II INC	2535 NW NORTH RIVER DRIVE MIAMI, FL 33125

(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 A revisit to complaint investigation (complaint number 2019014808) was conducted at Victoria's Dedicated Retirement Home on . Deficiencies were identified at the time of the survey:	{A 000}		
{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	{A 165}		

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{A 165}	Continued From page 1 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 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) [illegible], neglect, or [illegible] 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	{A 165}		

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{A 165}	Continued From page 2 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 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 file an adverse incident report with the agency within one business day and fifteen days for one out of 12 (Residents #1) sampled residents. Findings included:	{A 165}		

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{A 165}	Continued From page 3 Review of Resident's #1 record showed the health assessment done on [redacted] indicated the resident was diagnosed with [redacted] gait disturbance and [redacted]. The physician documented the resident needed [redacted] administration and needed assistance with medications. Progress notes documents the resident screamed and insulted the facility's staff and the residents, and did not allow the staff to enter her room in different occasions. The resident called the police to complain that she did not receive food and that the administrator hit her on [redacted]. The police conducted an investigation in the facility. The staff observed that the resident had a knife and a scissor in her room on [redacted]. Police was contacted and they removed the knife and the scissor from resident's room and gave them to the administrator. On [redacted] the resident hit and pulled owner's hair. Resident's psychiatrist was contacted and the resident was [redacted] and transferred to the hospital. Interview conducted on [redacted] at 11:30 AM, Administrator stated that she called resident's primary physician, but she told her to speak with her psychiatrist. She said she was unable to reach resident's psychiatrist. She said that Resident #1 called the police and said that she hit her. The police opened a case and conducted an investigation. The police interviewed her at the police station and asked her not to be closed to the resident. She said that the staff saw that the resident had a knife and a scissors when they were cleaning her room. We called the police because the residents and the staff were scared	{A 165}		

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{A 165}	Continued From page 4 that she would hurt anyone. The police came, gave us the knife and the scissor and left. Next day she refused to get out of her room and hit the administrator. We contacted her psychiatrist and she was transferred to the hospital. She stated she did not file an adverse incident report with the agency. Interview conducted on . . . . . at 11:53 AM, Owner stated that Resident #1 had and we called an ambulance and 911 but the resident refused to go to the hospital. The police came and told us that they received a call from the resident saying that she did not receive food and the administrator hit and touched her inappropriate in the bathroom. Police opened a case and took the administrator with them to the police station. Another state agency also conducted an investigation in the facility. The staff observed that the resident had a knife and a scissor in her room and we called the police and they removed the items from resident's room. The resident was aggressive, hit me and pulled my hair. She also refused to eat and administered her . . . . She said she contacted resident's psychiatrist and the resident was transferred backer act to the hospital. On . . . . . at 10:42 am "I did not do it because the resident left the facility. The last surveyor did not tell me I was supposed to file an incident report." Class III Uncorrected	{A 165}		