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
	AL11969174	A. BUILDING: _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ERA COMMUNITY HEALTH CENTER LLC	1351 N KROME AVE HOMESTEAD, FL 33030

(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 complaint investigation (complaint number 2020001605) survey was conducted at New Era Community Health Center LLC on . Deficiency were identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(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. 59A-36.007 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 59A-36.012, 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 resident's whereabouts. The resident may travel	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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 an updated written record for three out of ten sampled residents after a significant change. (Resident # 2, #6 and #1) Findings Included: On during the tour of the facility, Staff A stated that Resident # 2 was currently at the hospital because Resident # 2 was feeling weak. A review of Resident # 2's records showed he was admitted to the facility on ... and a progress note dated stating the resident was observed passing out while he was sitting on the bench and was taken to the hospital for evaluation. A second progress note dated stated that the resident returned from the hospital. A third progress note dated ... stated Resident # 2 returned to the hospital due to . . A fourth progress note dated stated Resident # 2 returned from the hospital. A	A 025		

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A 025	Continued From page 2 fifth progress note dated . . . stated that Resident was observed declining in function, refused to eat and disoriented and doctor gave an order to send the resident to the hospital. Further review of Resident # 2's records showed a discharge summary from the hospital dated stating the resident should follow up with his Primary Care Physician (PCP) 2 - 3 days for 'Continuance of Care'. There was no documentation in Resident # 2's records that showed he received follow up care from his PCP after being hospitalized. On . . . . . at 10:50 am, Staff B stated "I called the PCP and she saw him at the hospital". Staff B stated "I don't remember when he went to see the PCP. We don't have documentation when the doctor came". A review Resident # 6's records showed a progress note dated stated "Resident was sent to hospital due to . . . . , refusing medication and food. PCP, Case manager were notified". A second progress note dated . . . . . stated "Resident returned from [hospital], PCP, Case Manager and son was notified". There was no documentation that showed resident was seen by a healthcare provider after a significant change. Review of Resident #1's record showed he was admitted to facility on . . . . . . Resident #1's progress notes dated stated " Resident was sent to a hospital for , and , PCP, care manager and legal guardian were notified." Notes on at 9 PM showed " Resident returned to hospital, PCP, case manager and mother were notified."	A 025		

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A 025	Continued From page 3 Additional patient instructions: " To continue compliant with medication and follow up . , , . ." "Follow up , , on with Psychiatrist and the physician (PCP at the ALF)." Further review showed there was no documentation whether resident went to the follow up , , . On at 11:02 PM The Administrator stated Resident #1 and #6 saw the Doctor as scheduled in facility but they did not have written documentation of it. On at 11:33 AM the primary care physician stated during interview that he went to the facility to see residents and for sure he attended their scheduled , , every month but he could not remember the dates and names of residents seen in facility because of the amount of residents he had seen. Class III	A 025		