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
	AL11910926	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA I, INC	182 WEST 9 STREET HIALEAH, FL 33010

(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 change of ownership survey was conducted at Villa Rosa I on [redacted]. Deficiencies were identified at the time of the survey.	A 000		
A 165 SS=D	429.23(&) FS; 59A-36.016 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. [redacted]; 2. [redacted] or [redacted] damage; 3. Permanent [redacted]; 4. [redacted] or [redacted] 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	A 165		

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A 165	Continued From page 1 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) , 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.	A 165		

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A 165	Continued From page 2 (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 agency may adopt rules necessary to administer this section. 59A-36.016 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 three (Residents #1) sampled residents. Findings included:	A 165		

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A 165	Continued From page 3 Review of Resident #1 record showed he was admitted to the facility on . Health Assessment done on indicated the resident was diagnosed with , , high-density lipoproteins ( ), , type 2. The physician indicated the resident was independent with eating, toileting and transferring; needed supervisor with bathing, and grooming and assistance with ambulation. Progress notes document that: -The resident was observed and verbally aggressive to the staff on . The resident had been the resident's room doors and when he was directed to the restroom he began screaming to the staff. When the staff assisted the resident with his bath, he became angry and threw the bottle of shampoo to the staff member. Staff contacted resident's primary physician and he ordered the resident and transferred to the hospital. -Resident was observed all over the facility rather than in the bathroom on . When the staff tried to re-direct the resident, he became aggressive with the staff and raised the cane with the intention to hit staff member. Staff contacted the physician and the resident was transferred to the hospital. -Resident was observed harassing a female resident on . When the staff advice the resident not to do this behavior, he became verbally aggressive to the staff and threatened to hit the staff with his cane. Resident's physician was contacted, and the resident was . The police was called for assistance. The police was contacted. -The resident was agitated and verbally aggressive towards staff when he was dropped	A 165		

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A 165	Continued From page 4 off from being on pass on . Resident hurt staff member by pushing her and hurting her . Physician was contacted and the resident was and transferred to the hospital. A 45 days' notice was given to the resident due to his aggressive behavior towards staff and residents. Physician was contacted and the resident was and transferred to the hospital. -A 45 days' notice letter was withdrawn on . Resident's behavior improved. Review of the Adverse Incident database did not show a report was file for Resident #1 incidents that occurred at the facility on and . Interview conducted on at 1:10 PM, Resident's #1 daughter stated, "I know that he has some issues with becoming aggressive, he had problems in the last facility; this is not new; then, he was transferred to this one." Interview conducted on at 2:05 PM, Staff E stated, "Resident #1 became aggressive and hit us sometimes." Interview conducted on at 3:30 PM, the administrator stated that she did not submit the reports one business day or fifteen days after for Resident #1. Class III	A 165		