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
	AL11969645	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUEVA VIDA ALF INC	403 NORTHWEST BLVD MIAMI, FL 33126

(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 2020015871) was conducted on at Nueva Vida on through . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=E	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making ... for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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	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 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 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 written record, update as needed, of any significant changes, any illnesses that resulted in medical attention, or other changes that resulted in the provision of additional services for two out of four (Resident #1 and #2) sampled residents. Findings Included: 1) Review of resident records showed Resident #1 was admitted to the facility on . Review	A 025		

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A 025	Continued From page 2 of the health assessment dated . . . showed the resident was diagnosed with . . . . . , status post of motor vehicle multiple . . . , . . . , failure, multiple . . . . . and residual . . . injury right . . Resident required medical drug administration and monitor of daily activities. The resident required supervision with ambulation, bathing and transferring; and assistance with . . , eating, grooming and toileting. Review of the progress notes dated . . . . . revealed the resident was aggressive, . . and wanted to hit resident and staff and attempted to take a knife. Interview conducted on at 12:40 PM, The Administrator stated Resident #1 was " " on more than one occasion, but she did not remember the dates. She said she called the police two times and sometimes the neighbors called the police for resident behavior. She stated the police transferred the resident to the hospital on one occasion, but she did not recall the date or the name of the hospital. Review of the hospital records showed Resident #1 was brought to the hospital on . . . . . by police as . Review of the police report revealed the police were called to assisted living facility (ALF) due to patient having self-injurious behavior by cutting himself and becoming aggressive towards the ALF staff. Patient reports that he has been having . . . . swings and problems with the ALF staff. The resident was admitted to the . . . . . unit. Review of the hospital record showed Resident #1 was on and transferred to a hospital. The resident was diagnosed with . .	A 025		

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A 025	Continued From page 3 Interview was conducted with Resident #1 father on [redacted] at 9:22 AM. He stated his son was transferred to a hospital on [redacted] with low [redacted], [redacted] and returned to the facility same day. He said his son was [redacted] on [redacted] and transferred to a hospital and admitted to the hospital on [redacted]. He stated he returned to the facility on [redacted] and Backer Act later that day and was sent to a hospital and remained at the hospital until [redacted]. He said his son was transferred to another facility because he did not want him to return to the facility. Review of the facility records showed there was no documentation of resident behavior concerns before [redacted]. There was no documentation of resident [redacted] 's and/or hospitalization's on [redacted], [redacted], [redacted], and [redacted]. 2) Record review showed Resident #2 was admitted to the facility on [redacted]. Review of the health assessment dated [redacted] showed the resident was diagnosed with [redacted] ([redacted]), [redacted], Left [redacted], Right [redacted], and [redacted]. The health assessment revealed resident needed assistance with ambulation, bathing, [redacted], eating, grooming, toileting and transfers, and assistance with walking with a device. Review of a progress note (no date) revealed the resident fainted and was transferred to a hospital on [redacted]. The resident returned to the facility on [redacted] with [redacted]. Review of the hospital record dated	A 025		

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A 025	Continued From page 4 revealed Resident #2 was transferred to the hospital via Emergency Medical System with a syncopal episode at the assisted living facility (ALF). The resident was diagnosed with , , , acute , injury and , . There were no evidence of or . The showed there was no evidence of acute . Resident discharged from the hospital to the facility on . Review of a progress note (no date) revealed Resident's 2 primary physician recommended to transfer the resident to the hospital on . Interview conducted on at 5:02 PM, Staff B stated Resident #2 (no date given) and was transferred to the hospital on , and then was sent to a Rehabilitation Center on . She said the resident had , surgery. On at 11:28 AM Resident #2 health care provider stated the resident was at a rehabilitation center for right , surgery recovery on . Review of the hospital record showed Resident #2 was transferred to hospital on and discharged on . The resident was diagnosed with , , , , acute , injury, , advanced , Type 2 , , and , . ( ). The resident had with decreased responsiveness and low , . On at 3:40 PM the representative from hospice services was contacted and stated Resident #2 was admitted to the Hospital on and discharged on . She	A 025		

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A 025	Continued From page 5 stated the resident was admitted under hospice care on and later transferred to the hospital on . The administrator stated Resident #2 showed a decline in condition and was transferred to the hospital on . The Administrator stated she did not recall the name of the hospital. Review of the facility records showed there was no documentation of Resident #2 decline in condition, no documentation of hospitalization's and/or return to the facility for the dates of , , , through and . Class III	A 025		
A 165 SS=E	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 165		

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A 165	Continued From page 6 (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 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic 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, through the agency ' s online portal, or if the portal is offline, by electronic 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	A 165		

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A 165	Continued From page 7 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 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	A 165		

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A 165	Continued From page 8 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 provide an initial adverse incident report within 1 business day after the incident and a full adverse incident report within 15 days of the incident, through the agency's online portal for two out of four (Resident #1 and #2) sampled residents. Findings included: 1) Resident record review showed Resident #1 was admitted to the facility on . . . . . Health assessment completed on indicated the resident was diagnosed with . . , , , status post of motor vehicle multiple . . . . . , , , , failure, and multiple . . . . . Residual injury right . . . . . The physician indicated the resident requires medical drug administration and monitor of daily activities. The resident required supervision with ambulation, bathing and transferring; and assistance with . . . . . , eating, grooming and toileting. Review of the progress notes dated revealed, "the resident was aggressive, , and want to hit any resident and	A 165		

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A 165	Continued From page 9 staff and attempted to take a knife. The resident will not return to the facility." Hospital record review showed Resident #1 was on and transferred to hospital. The resident was diagnosed with . Review of the police report revealed, "they were called to the facility due to patient having self-injurious behavior by cutting himself and becoming aggressive towards the staff." Interview conducted on at 12:40 PM, The Administrator stated Resident #1 was " " on more than one occasion, but she did not remember the dates. She said she called the police two times and sometimes the neighbors called the police for resident behavior. She stated the police transferred the resident to the hospital on one occasion, but she did not recall the date or the name of the hospital. Review of the hospital records showed Resident #1 was brought to the hospital on by police as . Review of the police report revealed the police were called to assisted living facility (ALF) due to patient having self-injurious behavior by cutting himself and becoming aggressive towards the ALF staff. Patient reports that he has been having swings and problems with the ALF staff. The resident was admitted to the unit. 2) Record review showed Resident #2 was admitted to the facility on . Review of the health assessment completed showed the resident was diagnosed with .	A 165		

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A 165	Continued From page 10 ..., ..., ... (...), ..., ..., Left , , Right , , and ... The health assessment revealed resident needed assistance with all the activities of daily living and assistance, and assistance with walking with a device. Review of a progress note (no date) revealed Resident's 2 primary physician recommended to transfer the resident to the hospital on . On at 11:28 AM Resident #2 health care provider stated the resident was at a rehabilitation center for right , surgery recovery on .... Interview conducted on ... at 5:02 PM, Staff B stated Resident #2 (no date given) and was transferred to the hospital on ..., and then was sent to a Rehabilitation Center on ... She said the resident had , surgery. Review of the adverse incident report system showed the facility had no incident reports filed for Resident #1 and #2. Class III	A 165		