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
	AL11965173	A. BUILDING: _____ B. WING _____	06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
XIOMARA HOME	4321 SW 1 STREET MIAMI, FL 33134

(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 2021006989) was conducted at Xiomara Home on to . A deficiency was identified at the time of the survey.	A 000		
A 025 SS=G	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 resident diets in accordance with rule	A 025		

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A 025	Continued From page 1 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 offer personal supervision as appropriate for each resident and failed to notify the appropriate health care provider to arrange for the necessary care and services to treat the condition for two out of seven sampled residents (Resident # 1 and #2). Resident # 1 from her bed and did not receive treatment until the following day when she was found to have sustained a left . Resident #2 from a chair and did not receive treatment until she complained of , and later found to have sustain left . Resident #1 and #2 identified as having risk and no preventive measures were put in place.	A 025		

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A 025	Continued From page 2 Findings Included: 1) Review of Resident #1 1823 health assessment dated 11 /13/2020 showed an admission date of and diagnoses of , history of [illegible] and functional decline. Health assessment showed 'Special Precautions: .' Resident needed assistance with ambulation, transferring, and eating. She required total assistance with bathing, , self-care (grooming), and toileting. Residents receive hospice services. On at 11:40 AM on a telephone interview was conducted with Resident #1 family, stated his mother in the facility on at around 3:00 AM while being taking care of 'supposable' by two caregivers. He stated, "the facility did not call me until around 11:30 AM and told me about my mother and she was not taken to the hospital until early afternoon, while she was in , ." On at 8:40 AM Staff B stated that she has been working at the facility since "I am a live-in staff, and do not have a specific day off, but take a day off when needed. I was working on when Resident #1 from the bed at around 2:45 AM. I was working by myself. I realized that she because I usually check on the residents twice or three times at night." When I saw her on the floor, I picked her up and I sat her on the sofa in the living room. I called the owner, and she came over and she checked her up and resident looked fine. The following morning, she ate her breakfast. The nurse from hospice came and checked her and	A 025		

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A 025	Continued From page 3 she did not think that she had anything wrong. I did not do anything else because I was very nervous, and I could only call the owner. The owner kept trying to contact the resident's son several times during the morning and he did not answer the phone until around noon. Around noon a technician from hospice came to the facility to do the , and it was determined that she had a on the , and she was sent to the hospital." On at 9:40 AM the Administrator stated that Resident #1 was in bed and around 2:45 AM the roommate heard a thump and when she opened her , she saw Resident #1 sitting on the floor and she call the caregiver. The caregiver came, found the resident on the floor, picked her up and sat her on the sofa in the living room and called me. I came to the facility around 3:15 AM. I checked her and gave her a yogurt. She ate it and went to bed. The following morning hospice staff came around 8:00 AM and tried to lift her up to bath her and she complained of . A case manager from hospice was called. were ordered. I tried to contact the son several times and he did not answer the phone, I left him several messages. Finally, at around 4:30 PM on I was able to reach the son and I explained everything and told him that we were waiting for the result of the . On at 9:30 AM the result came showing resident had a on the . She was sent to the hospital the same day. A review of Resident # 1's hospital records dated showed " resident was admitted to the hospital with left after a at the ALF. Per resident son his mother was trying to crawl out of bed and crawled over the rail and .	A 025		

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A 025	Continued From page 4 2) Review of Resident #2 1823 health assessment dated showed an admission date of and diagnoses of Athscel , Catry w/o Pedals, , , , , , and Special Precautions: . Resident need assistance with ambulation, eating, transferring, total assistance with bathing, , self-care (grooming) and toileting. Reside receive hospice services. On at 9:27 AM the Administrator stated that on at 9:00 AM," Resident #2 was sitting in the living room, and she tried to reach for a small pillow and . Staff C (caregiver) picked her up and put her on the couch. The certified nursing assistant from hospice came to the facility around 9:25 AM and when she tried to take the resident to the room to give her a bath, resident started complaining of , . "I called the daughter and hospice. The nurse practitioner from hospice came, evaluated the resident and a technician from hospice came and did the and the result was that she had the . An ambulance was call and she was taken to a local hospital." On , the daughter called to let me know that her mother was going to be taking to another ALF. On at 9:30 AM during a phone interview with the daughter of Resident #2 stated, "my mother on at 9:00 AM and they call me at 9:30 AM and told me that the staff from hospice realized my mother could not walk properly. When I arrived, the facility was waiting for the technician to do the and around	A 025		

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A 025	Continued From page 5 12:00 PM my mother was taken to a local hospital. She had a , surgery and she stayed there for a week and then I took her to another ALF, she was there until the beginning of , and then , on ." A review of Resident # 2's hospital records dated showed the resident was admitted to the hospital with left after a at ALF. 3) A review of the facility's precautions policies and procedures, dated , revealed, 'The Administrator or designee will assess each resident upon admission via the health assessment and intake questionnaire to determine needs of resident(s) and cautions that should be considered'. Review of Resident #1 and #2 health assessments found the residents had precautions identified on the health assessment and there was no documentation precautions was implemented. Review of Resident #1 and #2 records found the facility did not notify residents health care provider to arrange for treatment after the . Class II	A 025		