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
	AL11910963	A. BUILDING: _____ B. WING _____	R 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 Second Revisit to Complaint Investigation numbers 2022018995, and 2023000508 was conducted at Hazel Cypen Tower on , 26, 2023. A deficiency was identified at the time of survey.	{A 000}		
{A 165} SS=D	429.23(&) FS Risk Mgmt & QA 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 resident's condition before the incident; or	{A 165}		

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{A 165}	Continued From page 1 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 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	{A 165}		

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{A 165}	Continued From page 2 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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit an adverse incident report within 1 and 15 business days after the occurrence of an adverse incident through the Agency's portal for one of 26 sampled residents, (Resident 26). Resident 26 suffered injuries from a and was transferred to a local hospital for treatment. Findings included: Review of the facility's log showed Resident 26 had a with injury on . Review of the incidents reported to the agency by the facility, showed no record of the incident with Resident 26. Review of Resident 26's record showed a health	{A 165}		

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{A 165}	Continued From page 3 assessment dated [redacted] with a diagnosis of [redacted], History of Multiple [redacted], General [redacted]. The resident used a wheelchair, was forgetful, and was under hospice care with administration of medications. The resident had [redacted] precautions. The resident was independent when eating, needed supervision with grooming, and assistance with ambulation, bathing, [redacted], toileting and transferring. A review of the resident record for [redacted] at 5:06 AM showed the wife of the resident came to the nursing office to notify the nurse resident and is on the floor [redacted]. Nurse went to assess, and upon arrival, the resident was found on the bedroom floor on a supine position in front of the dresser with a big [redacted] on his forehead, his wheelchair was at the end of his [redacted]; [redacted] noted all over the floor. Room floor noted free of clutter. Pressure added, resident awake, alert and verbally responsive no distress noted. Resident complained of severe [redacted] during assessment. Call placed to 911, and the resident was transferred to a local hospital for evaluation. Resident was transferred to [local hospital] via emergency. In addition, the record for the resident, showed a 45-day notice dated [redacted], stating, "[Resident 26] has suffered multiple [redacted], and interventions are not preventing the [redacted]. [The facility] cannot longer meet your current service needs and continue to provide services to you as appropriate." On [redacted], at 1:03 PM, the Administrator stated, "We did not transfer him	{A 165}		

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{A 165}	Continued From page 4 before because the family could not afford it, and they applied for Long Term Care (LTC) and Medicaid. We cannot put them on the street. At 1:36 PM he stated, "We don't know why it was not report it." At 2:00 PM he stated, "He did not call for assistance and lives with his wife." Uncorrected Class III	{A 165}		