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
	AL11968954	A. BUILDING: _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCES AT MIAMI	9355 SW 158TH AVE MIAMI, FL 33196

(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 2023011699) was conducted at The Residences at Miami, on , to , . A deficiency was identified at the time of investigation.	A 000		
A 025 SS=D	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 Resident Care Standards. 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		

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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 provide care and services appropriate to the needs of residents accepted for admission and failed to provide personal supervision as appropriate for each resident for one out of seven sampled residents (Resident # 1). Resident # 1 had an unknown injury to the . . . Findings included: A review of the facility's record showed Resident #1 acquired an unknown injury to the . . .	A 025		

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A 025	Continued From page 2 Review of Resident 1's 1823 health assessment dated , showed diagnosis of with behavioral disturbance, , major , and . Further review of the health assessment showed the resident used a wheelchair for safety. He was aggressive, combative, and had agitation. The resident had precautions, and needed assistance on all activities of daily living, and assistance with medications. Review of the hospital Emergency Room report for Resident # 1 showed an admission and discharge date for , with a diagnosis of of right with a boxer's . The report stated that the resident had a minimal displaced involving the adnexa of the fifth , bone and suggested to follow up with an orthopedic surgeon few days after the hospital release. On , , at 1:23 PM, Staff C (Nurse) stated, "regarding the resident , I cannot remember the exact date, but in the morning at about 11:00 AM when the staff was assisting him with his bath, she noticed that his hurt him at touch, and it was a little . The doctor was contacted and was going to send a mobile , but that would take about 3 days. He was sent to the hospital, and diagnosed with boxer , which is a punch. We [staff] could not determine how he injured his and there was no indentation on the wall. On , , at 1:34 PM, Staff D, Certified Nursing Assistant (CNA) stated, "I worked the day shift, and was assigned to the fourth floor. [Resident # 1] was on another floor,	A 025		

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A 025	Continued From page 3 he was very aggressive. He tried to throw punches and curse the staff when they were assisting him. He was here for a few months, and I never really had to interact with him. When we receive a shift, we are informed of any incidents. In the morning, we bring them [Residents] down to the common area to do activities. Also, we do rounds every 2 hours and more frequently for those with risks of . . . On . . . . . , at 1:58 PM, the Director of Nursing (DON) stated, "[Resident 1's] family omitted a lot of stuff from us. We learned after he was gone that he was very aggressive and got out of the house prior to coming here. He began to exhibit this behavior on the third or fourth day after admission, when he did not want to take a bath. Staff needed help to assist him. We talked with his wife and recommended a psychiatrist assessment and she agreed. We were giving him some time to adjust because probably the change from the house to here had affected him. The doctor was trying to find the right medication for him. The family was asking to give her a chance because she had to work and did not have another place for him. The wife asked us to please to keep him here, and that's why it took us this long to give them a 45-day notice of discharge. The psychiatrist changed the medications, but nothing worked. The DON stated, "regarding his . . , we are not sure how it happened, probably he hit something." On , , , at 1:20 PM, Staff E stated, "My shift is from 3:00 PM-11:00 PM. I am a CNA assigned to the third floor; [Resident # 1] was one of my residents. He was very aggressive from the first day that he was admitted. I reported him many times to the nurse. I used to speak with the wife, and she said that he was never like that.	A 025		

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A 025	Continued From page 4	A 025		

When I needed to change his briefs, I had to ask another staff member to help me. I know, they changed his medications, but he never improved. He never gave me a punch, but he grabbed my [illegible] and twisted them. I tried to be careful around him. About his [illegible], I did not work that day, but he was very strong and aggressive. He could hit anything and throw any object he had."

On [illegible], at 1:44 PM, Staff F stated, " [Resident #1] was always agitated and very aggressive, even with his wife. He was not aggressive toward other residents, only to staff when we approached him to assist him. He was at risk of falling and when he was seated and tried to stand up, a staff would try to help him, and he would throw punches to the [illegible] or kicking. He was verbally [illegible]; he called us names. It was very difficult to get close to him, he never punched me, but one time, he was in bed, and I leaned forward toward him, and I said, "[Resident 1] open your [illegible] to give medication" and he reacted and grabbed me by my [illegible]. I reported to my supervisor, [the DON]. They told us to be careful and patient with him because he was sick. I do not know what happened to his [illegible], but he threw punches at everything. We do rounds every 2 hours. "

On [illegible], at 2:26 PM, Staff G stated, "I am a CNA and work from 3:00 PM-11:00 PM and I am assigned to the first floor. On occasions I might have assisted [Resident #1] when he was in the lobby and took him to the bathroom. He was very difficult to control, very aggressive and agitated. On one occasion he grabbed me by my [illegible] and squeezed it hard. I do not recall that he ever was aggressive to other residents, nor did I see him punching another staff member, but I heard others talking about

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A 025	Continued From page 5 him and how aggressive he was. On [redacted], at 3:28 PM, Staff H stated, "from the first day, he [Resident #1] was acting very violently; when he got to the room, he punched the door. He would not communicate; he would always try to hit you. There was an incident where he got a staff in the corner, and because someone saw what's was happening, nothing worse happened. He never hit me because I learned to be more careful with him. He would not communicate that well. We would communicate every day with the administrator and [the DON], we write every day, any incidents and leave it at the nursing station. He wanted to go [redacted] to his home. Review of the facility records showed no documentation of 2 hours rounds being conducted for Resident #1 as stated by staff. Review of the facility records and staff interviews showed the facility was not able to identify how the resident sustained the injury to his [redacted]. Class III	A 025		