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
	AL11967486	A. BUILDING: _____ B. WING _____	12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALET AT OLD CUTLER (THE) LLC	7210 SW 148 TERRACE MIAMI, FL 33158

(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 #20230165385 was conducted on [redacted] through [redacted] at Chalet At Old Cutler. Defiiciencies were identified at the time of the survey.	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 [redacted] 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 resident diets in accordance with Rule	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 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 observation, record review and interview, the facility failed to maintain a written record, updated as needed, of any significant changes or illnesses that resulted in medical attention for one (Resident #1) out of three sampled residents. Findings: A review of the hospital records dated showed the following: "Female with unknown patient history brought in as a alert by emergency management system for a mechanical . Small right frontal , , hematoma."	A 025		

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A 025	Continued From page 2 Interviewed on at 9:00AM the Administrator stated, "She before in the recent past." The Administrator stated further that she (Resident #1) before, and she went to the hospital and that was why there was no intervention ( ) because she went to baseline. Regarding the on , the Administrator stated, "I was helping [Resident #2]. I found her on the floor down. I immediately I spoke with her. She was responsive. I did not touch her. I called 911 and told them this was an assisted living facility and that we have a lady on the floor and that she was . I checked on her at 3:30 AM. She was asleep like an angel. I did not see any . The police said that she had a hematoma on the forehead. I did not do any first aid. Because she was responsive. I did not want to touch her. The paramedics said that since this was , they were taking her to the hospital. She before in the recent past." Interviewed on PM at 3:38 PM the grandson of Resident #1 stated that he remembered a several years ago where she (Resident #1) received a , replacement. The grandson stated further that the Administrator never called them when she that time and that it was his grandmother who called them because she was in , . The grandson stated, "She (Resident #1) basically crawled in bed. My grandmother is kind of tough. She (Resident #1) did not have bedrails. She (Administrator) wanted to put a full bedrail and we did not want that. A review of Resident #1's observation log found no documentation of previous . .	A 025		

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A 025	Continued From page 3 A record review of Resident #1's observation log documented a on at 4:30 AM. A review of Resident #1's health assessment dated showed a woman and a diagnoses of Insufficiency and . The physical and sensory limitations showed "okay". The or behavioral status showed okay. The nursing/treatment/ services requirements showed "okay". The special precautions showed "none". The activities of daily living showed independent in ambulation, eating, self-care, toileting, and transferring, but needed supervision with bathing and . However, the care plan for physical and the policy for assistive devices dated showed Resident #1 used a walker and no half or full bedrails. Observation on at 1:00 PM found Resident #2 being pushed in a wheelchair by the Administrator. In addition to Resident #1's , Resident #2 was also to since there was no prevention nor intervention policy. A review of Resident #2's Health Assessment dated showed physical or sensory limitations with mobility related to . Resident #2 had a precaution and her activities of daily living showed supervision in ambulation, bathing, eating self-grooming, toilet and assistance needed with transferring. Interviewed on at 9:21 AM the Owner stated that they do not have a policy when asked.	A 025		

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A 025	Continued From page 4 When asked if Resident #1 injured herself and went to the hospital from her . a few years ago, the Administrator stated, "From the best of my knowledge, no! I have to check the records. I don't want to be incorrect." Class III	A 025		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a	A 162		

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A 162	Continued From page 5 therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of	A 162		

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A 162	Continued From page 6 the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for	A 162		

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A 162	Continued From page 7 facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update the health assessment for one (Resident #1) out of three residents after a . . . The facility failed to ensure accurate health for Resident #1 who used a walker. The facility failed to maintain a copy of Resident #1's required medication records. Findings: A review of Resident #1's observation log showed she (Resident #1) had a on at 4:30 AM. Further review showed showed Resident #1 returned to the facility on . A review of Resident #1's health assessment with a completion date of . . . . . showed her health assessment had not been updated to reflect the occurrence. In addition to Resident #1's health assessment, the activities of daily living showed Resident #1 was independent in ambulation. However, a review of Resident #1's care plan for physical . . . . . and assistive device policy dated showed she (Resident #1) used a walker. A review of Resident #1's records found no medication records for Resident #1. Interviewed on at 12:20 PM when asked why [Resident #1's] health assessment was not updated when she returned to the facility, the Administrator stated that the [resident]went to baseline. The Administrator stated that	A 162		

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A 162	Continued From page 8 [Resident #1] used a walker. Interviewed on [redacted] at 9:56 AM the Administrator stated, "We did not have her medications records. She was independent. Her daughter had the records." Class III	A 162		
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. [redacted]; 2. or , damage; 3. Permanent [redacted]; 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	A 165		

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A 165	Continued From page 9 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) [redacted], neglect, or [redacted] 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.	A 165		

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A 165	Continued From page 10 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. 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 for one (Resident #1) out of three sampled residents who had a and was hospitalized with hematoma. Findings: A review of Resident #1's observation log showed Resident #1 had a on at 4:30 AM while alone in the bathroom, and she required emergency hospitalization.. A review of the Adverse Incident Report records showed no for Resident #1 reported. A review of Resident #1's records showed there	A 165		

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A 165	Continued From page 11 was no intervention plan after first to prevent the on . Interviewed on at 9:00 AM, the administrator stated regarding Resident #3, the Administrator stated, "She before in the recent past. I talked to the family to get a bed side rail. She was independent. She used a walker. She did not have a bedside rail at the time. She went to the hospital." Interviewed on at 9:00 AM when asked if an adverse incident was filled out, the Administrator stated, "I don't know because this was considered an accident versus an incident, and this was why I did not report it." The facility written procedure and training requirement policy for adverse events states: "Within one hour (1) complete with Administrator [Agency] Adverse Incident Report (1 day)." Class III	A 165		