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
	AL11968102	A. BUILDING: _____ B. WING _____	R 01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER FAMILY HOME 11, INC	1024 SW 11 STREET MIAMI, FL 33129

(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 revisit to a re-Licensure survey was conducted at Ebenezer Family Home 11, Inc. on [redacted]. & [redacted]. A deficiency was identified at the time of the 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. [redacted]; 2. [redacted] or [redacted] damage; 3. Permanent [redacted]; 4. [redacted] or [redacted] 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	{A 165}		

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

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{A 165}	Continued From page 2 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 the records review and interviews, the facility failed to file a report with the Department of Children and Families when on of six sampled residents (Resident # 1) was assaulted by his roommate. Findings: A review of the incident report database revealed that the facility filed a report when Resident # 1 was assaulted by Resident #2. A review of facility records showed, "[illegible] at 7:15 am: Today during the night, [Resident # 2] fought with [Resident #]. When [Staff B] went to see them, [Resident #] hit [Resident # 1]; Staff separated them and asked [Resident #5] to help [Staff B] separate them. We called the Doctor, but because it was Saturday, he didn't return the call. On Sunday, at 11:00 a.m., we called the guardian	{A 165}		

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{A 165}	Continued From page 3 a few times and sent her a text message but did not return the calls. We asked [Resident # 1] if he wanted to go to the Hospital, and [Resident # 1] said no. At 12:30 p.m., [Resident # 1] continued to stabilize; the guardian still did not return the calls, and neither did the doctor. [Resident # 1] refused to go to the hospital because he felt ok." Review of the state agency's documentation dated showed, "[Resident #1] was asleep when he was by his roommate, [Resident #2]. On , early in the morning. The resident who did the was sent to a , hospital for further evaluation, however there was no incident reported noted because the victim was supposedly seen by the facility house doctor. [Resident #1] was observed and appeared to have severe injuries. His was completely on the right side. The administrator stated that the was at the facility living in the same room as the victim. The facility did not report this to the local authorities for proper investigation." A review of resident and facility records found no documentation that the was reported for investigation, and there was no documentation that a police report was made. On at 2:24 PM, during a telephone interview with the administrator he stated that he did not file a report with the Department of Children and Families because Resident # 1's guardian filed a report, and an investigation was conducted. Class III	{A 165}		

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