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
	AL11964549	A. BUILDING: _____ B. WING _____	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE'S PROGRESSIVE HOME CARE	80 NE 166 STREET MIAMI, FL 33162

(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 (#2023017299 and 2023017421) Survey was conducted at Lee's Progressive Home Care on . Deficiencies were identified at time of the visit.	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 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 record review and interview, the facility failed to have progress notes about hospitalization for one out of four (Resident #1) sampled residents. Findings included: A review of the facility's admission and discharge log showed Resident #1 was admitted and discharged on [redacted] to hospital. A review of Resident # 1's records had no progress notes available for review. Administrator stated, "I took them home with me to updated them."	A 025		

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A 025	Continued From page 2 In an interview on at 9:22 AM Staff B stated, "Resident #1 . One day she got up to go to the bathroom. Then I saw she turned , back in her room. That morning, she said she could not walk to the dining room for breakfast. So I told her I would bring it to in the room and she could eat it there. When I got to the room, she was sitting but was unbalanced when I saw here. Swaying over like she could not sit up straight. I told her I would call the primary to let him know what was happening and that she would be sent to the hospital. I called 911 . Resident #1 said she did not want to go to the primary or a skilled nursing facility. I told her, she had to go to the hospital and called 911. When rescue arrived they took her , and transported her to the hospital. A couple of days later the hospital contacted me and told me she was not walking. The place her in hospice because she had , I did not even know that. Resident #1 was private with her medical stuff. She was going to her regular , . Transportation would pick her up and she would go herself. Her doctors were at [Medical Center]. She handled all her affairs. Even the family did not know. After that she went to a rehab nursing facility. They communicated with her doctor and once she was place in hospice. She on hospice." In an interview on at 12:42 PM the Administrator stated, "Resident #1 was not feeling well. She was not steady to walk so Staff B called 911 and the rescue came and had her transported to the hospital. While she was at the hospital she stop walking and was transferred to a rehab and the placed under hospice where she later , . I did not file an adverse incident.."	A 025		

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A 025	Continued From page 3 Class III	A 025		
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 7. An event that is reported to law enforcement or its personnel for investigation; or	A 165		

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A 165	Continued From page 4 (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 disciplinary action, in which case the provisions of s. 456.073 apply.	A 165		

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A 165	Continued From page 5 (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 one and 15 days of the incident for one out of four (Resident #1) sampled residents. Resident #1 required medical attention and the transfer from the facility to a unit providing more acute care. Findings included: A review of the facility's admission and discharge log showed Resident #1 was admitted and discharged on to hospital. In an interview on at 12:42 PM the Administrator stated, "Resident #1 was not feeling well. She was not steady to walk so Staff B called 911 and the rescue came and had her transported to the hospital. While she was at the hospital she stop walking and was transferred to a rehab and the placed under hospice where she	A 165		

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A 165	Continued From page 6 later , ... , I did not file an adverse incident.." A review of the Adverse Incident Report database showed no documentation of a report regarding this incident. Class III	A 165		