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
	AL11910916	A. BUILDING: _____ B. WING _____	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS PALMAS SENIOR LIVING	5300 West 16 Avenue HIALEAH, FL 33012

(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 # 2024010803) was conducted at Las Palmas Senior Living on and concluded on . The provider had a deficiency identified at the time of the survey.	A 000		
A 025 SS=G	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 interview and record review, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for one out of sixteen sampled residents (Resident # 1). Resident #1 sustained a . that caused her to injure her ankle. Findings included: On at 2:27 PM, the Director of Resident Care Services stated that Resident #1 was at the hospital for something related to her	A 025		

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A 025	Continued From page 2 . . . When she returned to the facility on , it was indicated in her care plan that two staff must assist her with bathing. That information was written on the board at the nursing station and the nurse supervisor communicated to the direct care staff as well. In this case, the CNA (certified nursing assistant), Staff D did not wait for the other CNA and bathed the resident by herself, when she was going to grab the towel, Resident #1 lost balance and when Staff D tried to hold her, both on the ground. The Director of Resident Care Services stated that afterwards she assessed the resident and called the doctor. Resident #1 did not complain of any , but in the afternoon, she noticed the resident's ankle was getting . Then, she called again the doctor who ordered an , The mobile , arrived, and they found Resident #1 had a displaced . . . . in her . . , so they sent the resident to the hospital. At the hospital, they put a . . . . and a . . . . to Resident #1 and a few days later the resident was transferred to a rehabilitation center. On . . . . . at 3:42 PM, Staff D stated that she used to assist Resident #1 with showering by herself, but the resident was at the hospital recently and when she returned, the facility changed her care plan to be bathed by two people. On , Resident #1 wanted to get her shower, but the second staff was doing something else, so she thought could do it by herself as before. But in the shower, when she was grabbing the towel, Resident #1 started falling, she embraced the resident, but both together to the floor. Review of service plan of care for Resident #1 updated showed that the resident required two people to assist with bathing,	A 025		

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A 025	Continued From page 3 ambulation, , toileting and transferring. Review of medical records received revealed that Resident #1 was seen at the emergency room on for complaint of lower , after a . Then, Resident #1 was admitted to the hospital on for , /casting of closed right ankle and . A review of Resident #1's health assessment completed showed medical history and diagnoses of injury at right , , , ( ), ( ), (HLD), , , ( ), functional decline, left replacement surgery, left carotid surgery, right , and risk. The physician indicated that the resident had right side and needed safety universal precautions. Resident #1 needed assistance with ambulation, bathing, , self-care (grooming), toileting, transferring and with the self-administration of medication. A review of the facility's Prevention Policy revealed that: " In the interest of residents' safety, it is the responsibility of all personnel at [Facility] to participate in the prevention and management program. All cannot be prevented; however, interventions may help minimize risk of accidents and injury. To ensure residents at risk for are identified early and appropriate interventions are implemented in a timely manner. To minimize risk of and related injury." Class II	A 025		