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
	AL11966320	A. BUILDING: _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ERA	815 WEST DAUGHTERY RD LAKELAND, FL 33809

(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 (#2025005388) was conducted at New Era Assisted Living on - . . . . . . Deficiencies were identified at the time of the survey. A Class I deficiency was found at Tag A0152. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. New Era Assisted Living facility failed to ensure that all existing mechanical systems were repaired and maintained in good working order in accordance with standardized fire safety rules and regulations. The Class I noncompliance began on , . . The facility's Administrator was notified of the Class I noncompliance on at 2:55pm. The census at the start of the survey was 48. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 152 SS=J	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to	A 152		

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A 152	Continued From page 1 section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable _ to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the assisted living facility failed to ensure that the fire hood suppression and sprinkler systems were	A 152		

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A 152	Continued From page 2 maintained in good working order . The facility also failed to provide a safe living environment free of hazards by failing to adhere to standardized fire safety rules and regulations. The facility's noncompliance placed all 48 residents, including two dependent residents, at risk of imminent danger or harm. Findings Included: The following observations were conducted on between 8:55 AM to 3:00 PM. The Assisted Living Facility was a one-story facility with a census of 48. During a tour of the kitchen conducted on at approximately 9:10am, a red tag of non-compliance issued by the local Fire Marshall was observed on the fire suppression system piping. The writing on the tag noted that it was placed on due to a hole in the hood and was not in compliance. The oven was on with food observed to be cooking inside. (photographic evidence obtained) During an interview conducted with Staff D on at 9:06am, Staff D stated, "Yes, I cook food in the kitchen and use the stove and oven. The Administrator told me the fire inspector fixed the issues, and it was okay to cook." During an interview conducted with the Administrator on at 9:55am, the Administrator stated, "We thought when the repair was made, we could cook. The hole in the hood has been repaired. We use the oven but not the stove."	A 152		

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A 152	Continued From page 3 During an interview conducted with the local Fire Inspector on at 10:04am, the Fire Inspector stated that the facility was not allowed to cook in the kitchen at all. The Fire Inspector also stated the facility was not allowed to use the stoves or the ovens, as it is a huge safety risk. During an interview conducted with the Administrator on at 10:08am, the Administrator stated that an outside vendor came out to fix the suppression hood in , . The Administrator stated the facility was told the only way the red tag could come off was if another outside vendor did an inspection on the hood suppression system. The Administrator agreed no one has come out so far to do an inspection. An observation of a fire panel at the front door conducted on at 8:55am showed an orange light indicating the panel was silenced and displayed a message that read "trouble mode". (photographic evidence obtained) During an interview conducted with the Administrator on at 12:15pm, the Administrator stated that there was another problem with the fire panel and sprinkler system that needed to be repaired. The Administrator was unable to specify the additional problems with the panel. During a tour of the facility common area conducted on at approximately 9:05am, an additional fire panel was observed on the right side was observed with an orange light indicating a silent mode and read "trouble". The door to the right side of the fire panel had big dents and paint was coming off. (photographic evidence	A 152		

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A 152	Continued From page 4 obtained) During a tour of the outside of the facility conducted on at about 11:30am, a red tag was observed on the fire sprinkler water pipe issued by a local Fire Inspection company. The red tag indicated it was placed on for non-compliance. (photographic evidence obtained) During an interview with the Administrator conducted on at approximately 12:08pm, the Administrator stated the facility was aware that the red tag was still on the water sprinkler and the facility was waiting for an Inspector to come out. During an interview conducted with the local Fire Inspector on at 11:40am, the Fire Inspector stated that the facility's noncompliance was referred to local Code enforcement for further action on , since none of the corrections have been made. During a record review conducted on of multiple Fire Inspection Reports, there were numerous violations found between the dates of through . The violations have not been corrected. The violations include: " - Fire Sprinkler still red tagged and alarm is in trouble mode needs to be fixed by . - Nothing has been done sprinkler is red tagged and alarm is in trouble mode. - Numerous Deficiencies, fire alarm is working, but water tanks are passed due and	A 152		

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A 152	Continued From page 5 yellow tagged, sprinkler is red tagged, three outstanding $58 fines and I'm adding another $58 fine. If deficiencies are not corrected by a $500 assessment will be assessed. - Alarm is in trouble mode and silenced. I will return in one month. $58 assessed. - Nothing has been fixed. $58 assessment. Turning over to code enforcement. Fire Marshal will come next week to discuss movement forward. - Violations still found will return , on Fire Watch and need to keep a log". (photographic evidence obtained) During an interview conducted with the Fire Inspector on at 11:03am, the Fire Inspector stated a follow visit was conducted to the facility on and none of the previous violations were cleared. The Fire Inspector stated the facility has been on fire watch for over a year. The facility was made aware that they were on fire watch and were instructed to keep a log which the facility failed to maintain. During a tour of the hallways conducted on between 9:10am and 11:00am the following was observed: A chair blocked the two fire exit doors on both sides in the of the facility leading to the courtyard. A hospital bed and wheelchair blocked a fire exit on the left side of the facility. Behind an exit door to the backyard there was a pile of old mattresses, bed frames and other trash blocking the walkway to the backyard. The fire exit doors on the right side of the facility were also blocked with furniture. (photographic evidence obtained)	A 152		

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A 152	Continued From page 6 During an interview with the Administrator conducted on at 9:45am, the Administrator stated it was unclear why staff thought that it was okay to use the outside area as storage. The Administrator agreed all five fire exit doors were blocked. During a tour of the front lobby conducted on at 8:55am, a missing ceiling panel was observed and the surrounding panels had water stains. (photographic evidence obtained) During an interview with the Administrator conducted on at 11:16am, the Administrator stated there was a clogged air conditioning line and the Administrator agreed the missing ceiling panel and discolored panels needed to be replaced. Resident #1 stated during an interview conducted on at 8;55am that the facility had water coming in through the ceiling panels. Class I	A 152		
A 180 SS=G	59A-36.019(1) FAC Emergency Management (1) EMERGENCY PLAN COMPONENTS. Pursuant to Section 429.41, F.S., each facility must prepare a written comprehensive emergency management plan using "Minimum Emergency Management Planning Criteria for Assisted Living Facilities," AHCA Form 3180-5006, , , incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-15964. The form is also available at:	A 180		

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A 180	Continued From page 7 https://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml. The emergency management plan must, at a minimum, address the following: (a) Provision for all hazards; (b) Provision for the care of residents remaining in the facility during an emergency, including pre-disaster or emergency preparation; protecting the facility; supplies; emergency power; food and water; staffing; and emergency equipment; (c) Provision for the care of residents who must be evacuated from the facility during an emergency including identification of such residents and transfer of resident records; evacuation transportation; sheltering arrangements; supplies; staffing; emergency equipment; and medications; (d) Provision for the care of additional residents who may be evacuated to the facility during an emergency including the identification of such residents, staffing, and supplies; (e) Identification of residents with 's or related , and residents with mobility limitations who may need specialized assistance either at the facility or in case of evacuation; (f) Identification of and coordination with the county emergency management agency; (g) Arrangement for post-disaster activities including responding to family inquiries, obtaining medical intervention for residents, transportation, and reporting to the county emergency management agency the number of residents who have been relocated, and the place of relocation; and, (h) The identification of staff responsible for implementing each part of the plan. This Statute or Rule is not met as evidenced by:	A 180		

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A 180	Continued From page 8 Based on observation, record review and interview, the facility failed to have an approved comprehensive emergency management plan (CEMP), an emergency environmental control plan (ECP) and failed to re-submit a revised CEMP within 30 days after rejection to the local emergency management agency. Furthermore, the facility failed to follow their facility's approved Emergency Power Plan that required three generators and on-site propane and gasoline to last for 96 hours. Additionally, the facility failed to provide evidence that services were acquired to test and maintain the three generators. The facility's failure to ensure compliance with emergency management requirements threatens all facility residents' safety and security. Findings included: An environmental safety tour was conducted on at approximately 9:45am with the facility Administrator. The facility had three portable generators available for use, kept in various locations throughout the facility premises. During the tour two propane tanks were observed in the backyard shed, both were empty. No other fuel sources were on site. During an interview with the administrator conducted on at 9:50am, she stated the generators should all be kept in the shed and she didn't know where the propane went. She also stated gasoline would be purchased if needed during a power outage. A review of the facility's CEMP conducted on revealed the last approved CEMP by local Emergency Management Services was from	A 180		

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A 180	Continued From page 9 . The facility's submitted CEMP on was rejected by the local emergency management agency. There was no evidence that the facility re-submitted a revised CEMP within 30 days after rejection. During an interview with the administrator conducted on at 2:01pm she stated that it had slipped her mind to re-submit a revised CEMP to the local Emergency Management Services. She didn't have the time to follow up. During an attempt to review a written policy to ensure that staff members can effectively and immediately activate, operate and maintain the alternate power source conducted on , none was provided. At approximately 9:30am on , the administrator stated she did not have a policy on how to operate the alternate power source. During an attempt to review the testing and maintenance records of the alternate power source, conducted on the records were not provided. The administrator stated during an interview conducted on at approximately 9:50am the Generators were not tested in the last few months. Class II	A 180		