STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968484	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUENA VISTA HEALTH CARE CORP	**4230 NW 196 STREET MIAMI GARDENS, FL 33054**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A complaint (CCR#2015009643) revisit survey was conducted on , 2016. Buena Vista Health Care Corp had deficiencies at time of the survey:

0010 Admissions - Continued Residency

Based on observation, interview, and record review the facility failed have updated health assessments after significant changes in activities of daily living (ADLs) for one out of four (#4) sampled residents. The facility also failed to ensure one out of four (#4) sampled residents met continued residency criteria.

Findings included:
Observation on / at 9:00 am revealed Resident #4 was in bed during the survey.

Interview on / at 11:20 am Resident # 4 stated, "I cannot walk, I want to stay on bed quietly."
Interview on / at 11:25 am the Administrator stated, "Resident #4 stopped walking and refused to walk; she panic." Administrator also stated, "I acknowledged that I cannot keep her here if she continues declining because it is difficult for my staff to transfer her. I spoke with Resident #4's son, and I am just waiting on him; she has no at this time; it healed "

Record review found Resident #4 (admitted)'s health assessment (form 1823) dated / reflected the following information:
History of , , ATHRSCL Native COR ART, CARD Device in SITU, Hyper , Chronic Kidney , D Deficiency and Iron Deficiency . Resident #4 is oriented x 3 and ambulates with walker. There is no or behavioral status reflected. Resident service requires as P/T, no elopement risk and ADLs needs assistance. Diet is regular and no stage indicated. Per form 1823 resident meets criteria to live in facility, needs assistance with self-administration of medication.
Record review of Resident #4's progress notes dated / / stated, "Resident has been showing signs of lower extremity . Physician gave script for . No problems with medication or with food."
Record review of Resident #4's progress notes dated / / stated, "X-ray back from physician mild . Moderate reasserts pain for x-ray resident complained about shoulder."
Record review of Resident #4's progress notes dated / / stated, "Resident has been steadily declining. Consulted with physician and family. Resident has been receiving meds as needed. Seems to be suffering from some form of . Constantly wants to be in bed and doesn't like to eat food."
Record review of Resident #4's progress notes dated stated, "Resident is still having issues with transferring. Still capable of ambulating with assistance. Still seems panicked at times. Consulting with

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physician."
Record review of Resident #4's progress notes dated / stated, " Resident needs lots of assistance when transferring not total care yet. Spoke with son about possible alternative."
Record review of Resident #4's progress notes dated / stated, "Resident has been declining. Doesn't want to eat all of her food. Resident developed bed on sacrum and has been healing. Almost gone. bed seems to be developing on left heal. Consulting with physician and son for possible hospice or alternating air mattress."

Class III

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appointed a separate manager for each facility, the Administrator supervised two families.

Findings included:

Review of the Florida Health Finder website revealed that the Administrator supervised two assisted living facilities. The facility failed to appointed a separate manager for each facility.

Interview on / at 10:00 am the Administrator stated that he supervised two facilities, and he did not have any manager appointed yet; however, he was in the process to get one.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968484 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BUENA VISTA HEALTH CARE CORP	4230 NW 196 STREET MIAMI GARDENS, FL 33054

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0030	Correction	ID Prefix A0054	Correction	ID Prefix A0055	Correction
Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	Completed	Reg. # 58A-5.0185(5) FAC	Completed	Reg. # 58A-5.0185(6) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0152	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.023(3) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE 2/2/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/12/2015	☐ YES ☐ NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Buena Vista Health Care Corp
4230 Nw 196 Street
Miami Gardens, FL 33054

Dear Administrator:

This letter reports the findings of a complaint revisit survey conducted on , 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

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