

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 07/12/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969174	(X3) DATE SURVEY COMPLETED 06/18/2018
NAME OF PROVIDER OR SUPPLIER NEW ERA COMMUNITY HEALTH CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 N KROME AVE HOMESTEAD, FL 33030	

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

0000 - Initial Comments

A Complaint (CCR #2018008544) Survey was conducted on _____ and concluded on _____. New Era Community Health Center Llc. (License #12989) with Limited Mental Health component had deficiencies at the time of the survey.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interviews, the facility failed to provide care and services appropriate to the needs of residents, and failed to maintain awareness of the general health, safety, and physical and emotional well-being and awareness of three out of 21 sampled residents (Resident #1, #2 and #15). After several months of inadequately addressed addiction and mental health issues resulting in hospitalization, Resident #1 attempted _____ by jumping 10 feet down from a second story balcony, sustaining a broken pelvis and several other broken bones. Residents #2 and 15 _____ and were injured, and the facility took no actions to prevent reoccurrence.

Findings included:

1) A review of Resident #1's hospital record dated _____ stated "_____, (year old) F (female) with history of drug and _____, jumped from the second floor of a building and landed on the 1st floor, approx. 10 ft. _____, stable complaining of lower back pain and LLE (left lower extremity) pain. Found to have pelvic _____, left ankle _____, sacral _____, and an incidental very severe spinal canal _____."

A review of Resident #1's file revealed the resident was admitted on _____. The health assessment dated _____ documented medical history and diagnoses: _____ type, _____ high _____ or behavioral status: awake, alert oriented x 3. Nursing/Treatment/_____, Service Requirements. Per the health assessment the resident is not an elopement risk. The resident is independent with all activities of daily living. The resident needed assistance with self-administration of medications. Progress notes dated _____ documented: patient went completely _____ crisis and jumped from the second floor of the facility. Fire rescue has called. They transported patient to the hospital. Administrator and owner were notified of the incident.

A review of the Resident #1's hospital admission dated _____, documented: _____ female with PMH (Prior Medical History) of _____ and _____ with one prior _____ attempt, who presented to hospital via ambulance with complaints of high _____ sugar on _____. At the time of admission the patient presented with _____, symptoms, dysuria, frequency, hesitancy, urgency that

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started about 3 days prior to admission, and got worse over time, however not accompanied by any complaint. The patient has not experienced similar symptoms in the past. In addition, the patient complains of A review of Resident #1's hospital admission dated stated "a woman with hx (history) of use use tobacco use (-dependent), (), () who presents on BA after calling police herself. Patient stated she relapsed on yesterday when "a dark side of me told me to go to over town and see what was going on." States "I have too much money." On at 9:08 AM interview with Resident #11 revealed "Around 3:30 PM, I was sitting in the corner, and I saw a lady on the balcony saying I want to kill myself. Nobody was around, she got on top of the railing and I said "Don't do it, don't do it." She cleared the way, got on top of the railing and jumped. She landed on her feet and . The staff were in the hallway. The staff got to there right away in 10 seconds or less than a minute. She landed on her feet and , she was complaining of pain. I did not know her and I had not seen her but they told me her name. I saw the staff doing vitals, they did what they had to do. The emergency department responded fast, they were here in about 5 minutes." On at 11:40 PM Staff T reported "I was working that day because I had a shift time change, I was working in the afternoon. I am a team leader, I was doing rounds when I heard Resident #1 had jumped and I was on the phone with another staff. I got to where she was, and the Resident was crying complaining of pain, the Resident was not or anything. The resident was responding to us, the ambulance had already been called. The resident was responding to the rescue people, but was in pain. Before the incident the resident was calm and normal, some days the resident would respond harshly but the resident was a calm person. The resident always took her medication." On at 1:41 PM Staff S stated, "When I got here I saw the resident on the floor, I was informed the resident had jumped from the second floor. The resident was saying that she wanted to die. The resident was complaining of pain, and kept on saying that I wanted to die. We kept on telling the Resident not to move. The Resident was responding very well. The resident told the rescue people name and date of birth. When they got there, the rescue asked us to leave." On at 2:30 PM Resident #14 stated, "I was sitting near the office, and I ran to get the staff. The staff were inside in the middle by the kitchen. I did not see what happened ...Resident #11 did. He told her not to do it. Resident #11 was the one that told me to call the staff and they got there right away. Resident #1 and I were friends, I used to visit the resident for a lighter. Resident #1 used to have a boyfriend, Resident #13 and they would go shopping. Resident #1 was that Resident #13 left."		

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Resident #13 left a few weeks before that happened. Resident #13 and Resident #1 used to smoke crack, they used to smoke with the "chicken man." Resident #1 offered to me one time, but I only smoke cigarettes." On at 10:07 AM requested to Owner for the phone number of Resident #1's psychiatrist and he looked at the resident's demographic sheet and said this should be her doctor. On at 10:12 AM contacted the doctor with the information provided by the Owner, the doctor stated "this is not my resident, I do to see patients at this facility, but I have never seen the resident." On at 3:13 PM the owner stated "I do not know if any of them are using drugs, we let some of the resident's that can go out go and what they do outside of the facility we cannot control. We have a drug policy that if we find out they are using drugs we give them a 45 day discharge notice. I would have to look for the policy it is in the contract when the resident is admitted." A review of the facility's contract showed there was no documentation of the facility's drug policy. On at 1:02 PM interview with Resident #1 in the hospital revealed, "I was very and scared because I had a pain going through my leg and my . I was constipated and feeling that I have to do #2 (bowel movement). I went to the hospital before. I complained that I couldn't do #2 and that my legs were , but they said there was nothing wrong with me. They gave me some pain killers, but the medications were not doing anything. I couldn't sleep. I had to push myself so that I could move around. My is now. I keep on coughing green stuff. I went back to the hospital again they said there was nothing wrong. I did not know what to do. I couldn't take it anymore. I wanted for the pain to go away, so I thought if I jumped and I wouldn't feel the pain anymore." She added "no, there was no one there when I jumped. There was staff, but not where I was. The owner knows I was doing crack. There is a guy who gave me \$60.00 so that I could get him some crack. His girlfriend wanted to smoke some crack. Another guy named chicken came to me and gave me \$20.00 to buy him crack. I wait until there was nobody around at night. I jumped over the fence to go to the house where a lady catches the drug dealers. The owner gives me \$54.00 a month. I had \$4000.00. I did not know about it. When I got to the facility. I would ask the owner to give me money every day so that I could go shopping, go to the movies with my friends, give money to Resident #13, but Resident #13 wouldn't take it. I also buy drugs and food that I like. The nurse said I broke my spine, my ankle, and inside of my belly. I don't want to wake up. I want to go to sleep and die. The pain does not want to go away." On at 4:06 PM interviewed Resident #1's psychiatrist "Resident #1 was my patient, I would visit her on a monthly basis. The patient was very compliant with medication and was eating well. The patient had a history of drug , , and ; however, the patient never		

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expressed any thoughts. The resident was highly functional, was alert and I was sure that the patient was able to function in the community and even had the capacity to work. The patient had completed the program successfully. The patient was stable. The patient did not have severe The patient had never been , and there was never any suspicion being The patient was very and agitated and was receiving medication for that. The patient always talked about history of drug , and never said anything about cravings or was struggling with wanting to take drugs. The patient was very social, but All this was documented in the facility. I do not know why this was not available, I leave my documentation in the facility. I will make sure the progress notes are provided to your agency." On at 4:30 PM the Owner reported "I did not know the resident was using drugs, the resident had this money from social security which is a large amount and I could not refuse to give the resident the money because the resident would get really upset. I would tell the resident not to use it for drugs or anything like that. The resident was always asking for more money and more money, and I would give it to the resident. I did not suspect that the resident was using the money for drugs." 2) A review of the facility's hospital record on revealed that from to , a total of 51 transfers to the hospital for various reasons. From the list were: Resident #2 admitted on for (hurt his hips) and Resident #15 admitted on for broken arm. A review of Resident #2's hospital record dated stated "Displaced of lesser of right femur, initial encounter for closed Patient from an upright position, while walking to the his bed. It was a slip and" Facility progress noted dated stated "Patient and hurt his hip." 3) Progress notes dated documented Resident #15 tripped over her shoes in her landing on her hand. went to get staff. A review of the facility's precautions policy stated "In the instance of a patient , the following steps will be followed by the administrator: complete an incident report and place in resident's chart." On at 1:54 PM the Administrator stated ""No we did not follow our policy." Class II 0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC		

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Based on observation and interview, the facility failed to ensure that over the counter medications for two of 14 sampled Residents (Residents #13 and # 14) were in a secured location in the shared

Findings included:

On, 2018 at 8:20 am, observed on a shelf inside a shared, two residents, Joint dietary supplement for Resident 13. Observed in a shared, two residents, Nasal Spray with Aloe and greaseless Muscle Rub for Resident 14.

On, 2018 at 8:20 am, the owner revealed the over the counter medications found in both that are shared by multiple residents.

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and interview, the facility failed to have labeled over the counter medications for two of 14 sampled residents' name (Residents #13 and # 14).

Findings included:

On, 2018 at 8:20 am, observed on a shelf inside a shared, two residents, Joint dietary supplement without a label with the name of the resident for Resident 13. Observed in a shared, two residents, Nasal Spray with Aloe and greaseless Muscle Rub without labels with the name of the resident for Resident 14.

On, 2018 at 8:20 am, the owner acknowledged that the over the counter medications were not labeled with the residents' names.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview the facility failed to ensure that 1 out of 19 sampled employees had received training in the areas of Adverse Incident Reporting and Assisting with Activities of Daily Living (Staff S) within 30 days of employment.

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Findings included:

A review of Staff S' employee file revealed the staff was hired on and there was no documentation the staff received the Adverse Incident Reporting and Assisting with Activities of Daily Living training.

On at 2:42 PM the Administrator stated "The staff was recently hired and we are the process of completing all the training."

Class III

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on record review and interview the facility failed to have a surety bond with the minimum bond proceeds that equal twice the value of the residents' monthly aggregate income for 52 residents.

Findings Included:

A review of the facility record revealed that the facility was the payee for 52 Residents and had a surety bond of only \$10,000.

During an interview on at 9:48 AM the Owner stated "I have the surety bond. I spoke with someone from the Agency office in Tallahassee who told me that the amount of money is not matter, I just have to have one. Yes, I read the regulations on the surety bond."

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a clean, free of hazards and safe living environment at 5 of 40 sampled (#12, #13, #14, #15 and #46).

Findings included:

On , 2018 between 8:00 am and 9:25 am during tour of the facility, observed with an odor. Observed had a leak at the shower faucet. Observed with the closet door broken. Observed with cigarette smell. Observed with broken drawers and broken

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window blinds. Observed with ceiling water leak and bucket on floor collecting the water while the Resident slept on bed. Broken screens observed between and 27 and all the elevators certificate of operation expired on On , 2018 at 8:00 am in reference to Staff A stated, "I will send someone to check it". At 8:05 am in reference to the owner stated, "We have been having problems with this shower; we fix it and it breaks again". At 8:10 am in reference to the owner stated, "I will get the maintenance man to fix it right away" and Resident 12 stated, "I did that because I felt like it". At 8:15 am in reference to the the owner told the Residents, "How many times have I told you not to smoke inside the ?". At 8:40 am in reference to the the owner stated, "I was not aware of the drawers but the Residents break the blinds all the time". In reference to , the owner acknowledged the leak on the ceiling. Class III 0162 - Records - Resident - 58A-5.024(3) FAC Based on record review and interview, the facility failed to have a completed health assessment for one out of 21 sampled Residents (Resident #2). Findings included: A review of Resident #2's health assessment on revealed that the date of examination was missing and it was not specified whether Resident #2 needed assistance with self-administration of medications. During an interview on at 3:25 PM the owner acknowledged that the health assessment was not dated and was incomplete. Class III 0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC Based on record review and interview the facility failed to file a one day incident report for two out of 51 sampled residents who were hospitalized (Residents #1 and #2). The facility also failed to file both, a one day and a 15 day incident report for 1 out of 51 sampled residents who and had broken bones (Resident #15).		

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Findings included: A review of the facility's hospital transfers from to, a total of 51 transfers were sent to the hospital for various reasons. From the list were: Resident #1 who attempted on, Resident #2 admitted on for (hurt his hips), and Resident #15 admitted on for broken arm. A review of Resident #2's hospital record dated stated "Displaced of lesser of right femur, initial encounter for closed Patient from an upright position, while walking to the his bed. It was a slip and" During an interview on at 1:54 PM the Administrator stated "I did an incident report today for Resident #1 because we were waiting for the hospital record. "We did not do any incident report for Resident #15 because the Resident ... in the we sent the resident to the hospital. Do we have to do incident report for that? Resident #3 too and we sent the resident to the hospital too." Class III L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC Based on record review and interview, the facility failed to provide proof of Limited Mental Health (LMH) training for one of 18 sampled staff within 6 months of hire (Staff E). Findings included: Record review of the licensed facility on Florida Health Finder database showed the facility had LMH as specialty license component. Record review for Staff E showed a hire date of 11/, staff did not have proof of LMH training within 6 months of hire. On at 10:30 am, the owner acknowledged that staff did not have proof of LMH training. Class III		