

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969174	(X3) DATE SURVEY COMPLETED R 02/15/2019
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 Standard Biennial second revisit survey was conducted in conjunction with a complaint investigation survey (CCR 2019000198) at New Era Community Health Center LLC. on [redacted] and concluded on [redacted]. New Era Community Health Center LLC had deficiencies identified at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28() FS 429.27

Based on record review and interview, the facility failed to provide Access to adequate and appropriate health care consistent with established and recognized standards for one out of 12 sampled residents (#1). It was reported that Resident #1 choked on a bagel during breakfast and staff on duty did not perform First Aid or [redacted] after the resident, who did not have a [redacted] (), was unresponsive.

Findings included:

Review of fire rescue records revealed that on [redacted] at 7:30 AM, the facility called the Emergency Medical Services (). [redacted] arrived to the facility on [redacted] at 7:36 AM. [redacted] staff performed at arrival to the resident. Staff reported to [redacted] that Resident #1 choked and collapsed five minutes prior to arrival. The resident was (). Resident #1 was not breathing and did not have a [redacted]. [redacted] removed the obstruction and the residents was treated, monitored and transported to the hospital. Resident #1 had a [redacted] caused by [redacted] / asphyxia.

Review of Resident #1's record at the facility found it did not have a [redacted]. Resident #1's progress notes stated that on [redacted], the resident went to the hospital (the hospital name was not documented) because he was complaining of [redacted]. The facility did not have any notes regarding Resident #1 choking on a bagel or receiving First Aid and [redacted] from [redacted].

On [redacted] at 11:50 AM, the facility owner revealed Resident #1 went the hospital but he did not know why the resident was transferred to hospice but he [redacted] under hospice care. That hospital provided by the owner was contacted on [redacted], they revealed Resident #1 did not receive any services from them in [redacted] (2018). On [redacted] at 11:50 AM, the administrator reported Resident #1 was transferred to a different hospital.

Review of hospital records for Resident #1 revealed he arrived to the hospital on [redacted] at 8:30 AM. Fire rescue reported Resident #1 ate a bagel at the assisted living facility and choked. History of present illness showed that he had a [redacted], and [redacted] () at [redacted].

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 03/04/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969174	(X3) DATE SURVEY COMPLETED R 02/15/2019
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)		
the ALF (Assisted Living Facility). He received , amp of , and bicarb, and regained . The physical examination showed that he was intubated on support. Pupils were sluggishly reactive to light. He was comatose, nonresponsive to any verbal commands. He was and , his did not open at the arrival to the hospital. Intensive care diagnoses included acute , failure and hypoxemia, status post and , anoxic (caused by lack of delivery to the), and recent choking on food. He was transferred to hospice to provide comfort measures only and terminated life prolonging treatment. On at 11:41 AM, Staff C reported she has worked for the facility for around 2 years. Staff C stated she has the First Aid and training. Staff continued to say she remembered Resident #1. She was on duty the day that the resident was transferred to the hospital by the rescue. Resident #1 came and stood at the counter after breakfast was served to him. He looked at her and did not appear well, he was shaking and had breathing with problems. The staff grabbed the resident by the , and helped him to get in the floor because he looked like he was going to . Another staff member called -1. The emergency services asked her if he was breathing, to what she answered "yes" because he was breathing. The resident did not talk to her but he was breathing (fire rescue records documented Resident #1 was not breathing upon arrival). The -1 arrived immediately, it was fast. The emergency service staff told her to move to the side and she did because they started to work with the resident. She revealed that she did not perform because he was breathing with problems but he was breathing. She did not think that he choked. The resident did not press his or . Despite having First Aid training documentation, Staff C stated, if someone chokes, she needs to put the resident's arms up and hit the person with her on the . According to American Association Saver Adult Choking steps during the First Aid training: - Recognize a severe airway " Makes the choking sign " Cannot breath, , speak, or make sounds (Ask if the person ok? if the person makes signs of yes, ask if needs help?). - Give thrusts slightly above the belly button until " Object is forced out or " Person becomes unresponsive If the person stops responding " Shout for help " Phone or have someone else phone -1 and get . Put the phone on speaker mode so that you can talk to the dispatcher.		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 03/04/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969174	(X3) DATE SURVEY COMPLETED R 02/15/2019
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)		
" Provide . . . if needed, starting with " Look in the If you see an object in the, take it out. ¢ Give 2 (two) breaths and then repeat 30 ¢ Continue . . . until the person moves, speaks, blinks, or otherwise reacts. ¢ Someone with more advanced training arrives and takes over. On . . . at 10:30 AM, the facility's owner revealed that he was going to send their internal incident report that the facility completed when the incident happened on The internal incident report received on . . . at 11:05 AM documented the incident occurred on . . . at 7:30 AM and the person reporting the incident was Staff C. The description revealed Resident #1 was having breakfast when he started to grab his . . . in . . . The staff instructed another worker to call . -1 immediately. She assisted the resident to the floor and laid him on his side as per . -1 instructions. The . -1 operator asked her if the resident was breathing ok and if he was . . . Staff C informed the operator that he was . . . and was breathing fine. Staff C remained on the phone with the . -1 operator until rescue arrived. Rescue transported Resident to the hospital for medical attention due to severe . . . pains. Class II 0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(l) Based on observation, record review, and interview, the facility failed to identify one out of 12 sampled resident (Resident #12) who was at risk of elopement. The facility also failed to follow its elopement procedures. Findings included: Review of Resident #12's file on . . . showed a Health Assessment dated . . . with medical history and diagnoses: . . . type. Resident #13 was identified as an elopement risk. Review of the facility's elopement procedures on . . . stated "if elopement risk is determined, the following actions will be taken: a) an identification bracelet will be placed on resident's . . . with his/her name and facility contact information." In an interview on . . . at 12:51 PM, the Owner stated "Resident #12 took the bracelet off" the Owner left came . . . and handed a sample of the facility's bracelet.		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969174	(X3) DATE SURVEY COMPLETED R 02/15/2019
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)		
Class III 0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC Based on observation, interview, and record review, the facility failed to provide a safe living environment. Findings included: During a tour of part of the first floor of the facility on at 8:09 AM, . . . # was observed to have two medium dark stain that looked like a mold and water damage in the ceiling by the bathroom and . . . # was observed to have peeling paint and a large dark stain that looked like water damage in the ceiling by bathroom. In an interview on at 8:17 AM, the Owner said "I am going to change it now." On at 8:09 AM, there were loose tiles on the shower of . . . # 's; also, the shower floor had soap scum. On at 8:14 AM, there was a strong cigarette in . . . # . On at 8:14 AM, Staff F revealed that the facility's staff told to residents that they cannot smoke in the facility. On at 8:16 AM, there were loose tiles on the shower of . . . # 's; also, the shower floor had soap scum. On at 8:18 AM, there was a coffee maker in the bathroom in . . . # . The shower continuously leaked water. There was a strong . . . odor in bathroom. The paint next to the inner window was peeling. On at 8:19 AM, Staff F revealed that probably one of the residents in . . . # . . . in the trashcan in bathroom. On at 8:21 AM, there was loose sealed between the wall tiles and the floor tiles in the shower of . . . # . and the shower floor had soap scum. On at 8:24 AM, there were residual of cigarettes on the carpet floor in . . . # . On at 8:25 AM, there was a strong cigarette in . . . # . On at 8:33 AM, there was a strong cigarette in . . . # . On at 8:33 AM, Staff F revealed that both residents in . . . # smoke. On at 8:39 AM, the shower floor had soap scum in . . . # . The sink in the bathroom continuously leaked water. On at 8:45 AM, the shower floor had soap scum in . . . # .		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 03/04/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969174	(X3) DATE SURVEY COMPLETED R 02/15/2019
---------------------------	---	---

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)

Uncorrected Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to ensure that residents had an updated health assessment form identifying their past medical history and diagnosis for one out of six sampled residents (#4), and also the facility failed to have a completed health assessment for four out of 12 sampled residents (Resident #9, #10, and #11).

Findings included:

Review of Resident #4's record showed that the admission date was on The health assessment (AHCA form 1823) completed on indicating that the medical history and diagnoses section said "NONE".

Resident's hospital record showed she stated at the hospital from and her discharge date was on The discharge diagnoses were , and related findings.

On at 11:24 AM, the administrator revealed that the facility did not obtain an updated 1823 with the diagnoses for Resident #4.

Review of Resident #9's file on showed that the health assessment dated had missing information. The Physical or sensory limitations was not completed, Nursing/Treatment/ Service Requirements was not completed, and whether or not the resident needed help with taking medications was not completed.

Review of Resident #10's file showed that on the health assessment dated Nursing/treatment/ requirements was not completed, whether or not the resident needed help with taking medications was not completed. Special precautions stated that the resident needed elopement precautions, but he was not at risk of elopement. Resident #11's Health assessment dated and Resident #12's Health Assessment dated had Nursing/treatment/ service requirements not completed.

Review of Resident #11's health assessment completed on showed the medical history and diagnoses of It did not include that the medical diagnosis of Observation log dated stated, "patient is going to a local hospital due to

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969174	(X3) DATE SURVEY COMPLETED R 02/15/2019
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)		
Observation log dated [redacted] stated "patient returned from the hospital." Observation log dated [redacted] stated, "patient is going to a local hospital due to [redacted]." Observation log dated [redacted] stated, "patient returned from hospital." According to American [redacted] Association, [redacted] is a temporary loss of [redacted] usually related to insufficient [redacted] flow to the [redacted]. The patient can faint or pass out. Class III 0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23([redacted] & [redacted]) FS; 58A-5.0241 FAC Based on record review and interview, the Assisted Living Facility failed to file an initial adverse incident report with the agency within 1 business day and a full adverse incident report within 15 days of the incident for one out of 12 sampled residents (#1). Findings included: Review of the incident report database on [redacted] at 1:44 PM showed that the facility did not file any adverse incident report after [redacted]. On [redacted] at 9:50 AM, the owner revealed none of the residents has [redacted] in the facility in the last six months. The facility has not had any adverse incident since the previous survey. Review of fire rescue records revealed that on [redacted] at 7:30 AM, the facility called the Emergency Medical Services ([redacted]). [redacted] arrived to the facility on [redacted] at 7:36 AM. [redacted] staff performed [redacted] at arrival to the resident. Staff reported to [redacted] that Resident #1 choked and collapsed five minutes prior to [redacted] arrival. The resident was [redacted] ([redacted]). Resident #1 was not breathing and did not have a [redacted] removed the obstruction and the residents was treated, monitored and transported to the hospital. Resident #1 had a [redacted] caused by [redacted] / asphyxia. Review of hospital record for Resident #1 showed that he arrived to the hospital on [redacted] at 8:30 AM. He was admitted on [redacted] at 8:34 AM. The section of history of present illness showed that he had a [redacted] and [redacted] ([redacted]) [redacted] at the ALF (Assisted Living Facility). He received [redacted] amp of [redacted] and bicarb, and regained [redacted]. The resident ate a bagel and choked on his food. The physical examination showed that he was intubated on [redacted] support. Pupils were sluggishly reactive to light. He was comatose, nonresponsive to any verbal commands. He was [redacted] and [redacted], his [redacted] did not open at the arrival to the hospital.		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 03/04/2019
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969174	(X3) DATE SURVEY COMPLETED R 02/15/2019
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)		
Class III		