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
	AL11967124	A. BUILDING: _____ B. WING _____	R 06/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUNI ALF	370 NW 133RD PLACE MIAMI, FL 33182

(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 revisit to a complaint (CCR #201900125) survey was conducted at Zuni ALF on [redacted] and concluded on [redacted]. Deficiencies were identified at the time of the survey.	{A 000}		
{A 025} SS=G	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 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 resident diets in accordance with rule 58A-5.020, 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.	{A 025}		

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{A 025}	Continued From page 1 (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 care and services appropriate to adequately meet the needs of the residents. The residents sustained multiple with injuries, resulted in a injury, and for three out of six (Residents #1, #5 and #6) sampled residents. Findings included: Interview conducted on at 10:40 AM, the Administrator stated she implemented precautions to prevent residents and injuries. She reported she communicated with the residents that they need to ask for assistance when they need help. She stated that she posted signs around the facility to remind the residents about . In addition, she stated that she showed residents to explain the consequences of . She stated that they provided constant supervision. On at 9:06 AM, observed Staff B alone at the facility caring for five residents, three of	{A 025}		

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{A 025}	Continued From page 2 them were receiving hospice services. One of the hospice residents was bedbound. Record review showed Resident #1 was admitted to facility on . Resident #1's health assessment date stated that resident needed assistance with transferring, ambulation, , eating, self -care. Resident #1 had precautions. Medical Certification for long term services conducted on documented Resident #1 had a right , a , all over body and right , . An additional medical certification for long term services conducted on documented Resident #1 had a right arm , , and a on right , . Resident #5 was admitted to the facility on . Resident #5's health assessment dated stated the resident had a history of right , . The resident was independent eating, needed supervision with grooming and toileting, and required assistance ambulating, bathing, and . Resident #5 had precautions. Facility incident report documented that on at 08:15 AM, "Patient was out of the shower getting dress. Patient was stable and holding bathroom rail. She started coughing and lost control and ." Hospital records revealed Resident #5 was admitted on . Fire rescue arrived to the ALF site on at 8:40 to evaluate Resident #5 for a , injury. The chief complaint was for a and had discomfort on the lower right extremity. Imaging section stated	{A 025}		

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{A 025}	Continued From page 3 Resident #5 had of the right , six and seven . Correlate with point tenderness and , . Resident #6 was admitted to facility on . Resident's #6 health assessment dated stated the resident had a history of 's . The resident needed assistance with all the activities of daily living. Resident #6 had precautions. There was no documentation that the resident had a in her , right lower. There was no documentation that the resident received care. Facility incident report documented that on at 4:14 PM, "Resident #6 was sitting in the recliner, got up from her seat and try to take off/remove her bandage from . Patient loss balance, falling to the floor." Hospital record review showed Resident #6 was transferred to hospital on . The resident was pushed by another individual, to the ground and sustained a on the left side of her . The record document the resident had a in her , right lower. Hospice record review showed Resident #6 was admitted on . The physician ordered care to closed / suture line and , care. Attempted to interview Resident #6 at 10:20 AM. She was . Resident #1 at least four times in the facility, Resident #5 and broke her , and Resident #6 was pushed by another individual, to the ground and sustained a on the left side	{A 025}		

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{A 025}	Continued From page 4 of the . . . . There was no documentation that the facility develops a plan or intervention to avoid other . . in the facility. Class II Uncorrected	{A 025}		
{A 165} SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. . . . . or . , . damage; 3. Permanent . . ; ; 4. . . . . or . . . . . of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more	{A 165}		

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{A 165}	Continued From page 5	{A 165}		

acute care due to the incident rather than the resident ' s condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to

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{A 165}	Continued From page 6 disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to complete the one day and 15 day incident report to the Agency for two out of six (Resident #5 and #6) sampled residents. Findings included:	{A 165}		

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{A 165}	Continued From page 7 On at 9:50 AM Staff B stated Resident #5 on after bathing her. She stated resident was standing up grabbed of her walker and started coughing, she moved out from the walker and to her . She stated that after the staff called the rescue who transferred her to the hospital. She stated due to the Resident #5 had . Hospital records revealed Resident #5 was admitted on . Fire rescue arrived to the ALF site on at 8:40 to evaluate Resident #5 for a injury. The chief complaint was for a and had discomfort on the lower right extremity. Imaging section stated Resident #5 had of the right , six and seven . Correlate with point tenderness and . Resident #5 was admitted to facility on . Resident #5's health assessment dated stated Resident #5 had precautions. Facility incident report documented that on at 4:14 PM, "Resident #6 was sitting in the recliner, got up from her seat and try to take off/remove her bandage from . Patient loss balance, falling to the floor." Hospital record review showed Resident #6 was transferred to hospital on . The resident was pushed by another individual, to the ground and sustained a on the left side of her . The record document the resident had a in her , right lower. Resident #6 was admitted to facility on .	{A 165}		

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{A 165}	Continued From page 8 Resident's #6 health assessment dated . . . . . stated the resident had precautions. On at 11:32 AM, Administrator stated she submitted the adverse incident report for Resident #5 and #6 but did not know the agency requested additional information Class III Uncorrected	{A 165}		