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 08/19/2019

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 second revisit to complaint investigation (complaint number 201900125) in conjunction with a third revisit to a change of ownership survey and a complaint investigation (complaint number 2019011805) was conducted at Zuni Alf on [redacted] and concluded on [redacted]. Deficiencies were identified at the time of survey.	{A 000}		
{A 025} SS=D	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] or [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.	{A 025}		

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{A 025}	Continued From page 1 (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (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 record review and interview, the facility failed to maintain an updated written record documenting that a resident had an illness that resulted in medical attention for two out of six sampled residents (#6 and #3). The facility also failed to document when one out of six sampled residents (#4) returned from a hospital stay. Findings included: 1) Review of Resident #6's record revealed that there was a note indicating that she returned to the facility enrolled in hospice services. There was no documentation indicating that when the resident went to the hospital or the reason. On at 10:51 AM, Staff A provided a calendar for the month of , showing that the facility called the rescue and Resident #6 went to the hospital on . The resident returned to the facility on .	{A 025}		

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{A 025}	Continued From page 2 2) Review of Resident #3's record showed that the admission date was . The resident's the demographic data sheet showed that the resident had an to sulfa. The health assessment (AHCA form 1823) indicated that the resident had an to Sulfa and . The medical history and diagnoses included and the resident needed assistance with self-administration of medication. A review of Resident #3's discharge summary from the hospital showed that the resident had flank , on . The discharge summary indicated follow up was needed in 2 days with the primary care physician and the urologist. On at 12:03 PM, Staff A revealed that on Resident #3 had an intermittent , . She did not recall exactly if Resident #3 went to the hospital that date. Review of Resident #4's record showed a discharge summary from the hospital dated . The facility's progress notes showed that the resident's family member transferred the resident to the hospital on while she was out with the family member. Uncorrected Class III	{A 025}		