STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968767	10/08/2015
NAME OF PROVIDER OR SUPPLIER LA BELLA VIDA ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 7012 N ORLEANS AVE TAMPA, FL 33604	

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

0000 Initial Comments

Assisted Living Facility

A change of ownership (CHOW) state licensure survey was conducted on .

Valdespino ALF II, (formerly known as La Bella Vida ALF), had deficiencies identified at the time of the visit.

0003 Licensure - Change of Ownership (CHOW)

Based on record review and interview, the transferee had not fully complied with all requirements contained in Part II, Ch. 408, F.S. Section 429.12, nor had it notified in writing four of four residents sampled (#1-4) regarding the manner in which the transferee was holding their funds, the name and address of the depository where their funds were being held, the amount held, and the type of funds credited. In addition, the new owner was unable to produce written proof of any resident funds, advance resident payments, security deposits and resident trust funds that were transferred at the time of the ownership transfer.

Findings include:

A review of two resident files (#2; 3) during the change of ownership survey found no written notification from the new owner within 7 days of obtaining the provisional license that she was the new owner of the facility. Interview with the administrator at approximately 2:15 p.m. on confirmed that she had not disseminated anything in writing to any of her four (4) residents regarding transfer of the facility ownership. Further administrative record review found no evidence of a proof of transfer of resident funds/deposits/related monies that were exchanged at the time of the change of ownership of the assisted living facility. Interview with the administrator at approximately 2:20 p.m. on indicated that "these papers were filed elsewhere and were unavailable for inspection." Further interview revealed that "the written notification that told residents the name/location of the new financial institution where their funds/advance deposits, etc. had been transferred to" was also unavailable for review.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0054 Medication - Records

Based on observation and interview, the facility did not maintain an up-to-date medication observation record (MOR) with respect to one of two residents sampled (#2; 3) who were observed receiving assistance with their medication self-administration.

Findings include:

At approximately 1:10pm on , Staff A was observed assisting Resident #1 with his medications. One of these containers was for 420mg, 1 tablet 3x/day--noon was one of the times per the administrator. However, a review of the corresponding MOR found no entry for this drug. Interview with the administrator (Staff A) at approximately 1:15pm on provided no clarification as to why no official entry for the had been added to the current MOR for at least the last eight (8) days.

Class III

0078 Staffing Standards - Staff

Based on record review and interview, three of three staff sampled (A; C; D), had no official statements from a health care provider attesting to their freedom from communicable other than ( ).

Findings include:

Although personnel record review during the change of ownership survey indicated that Staff A, C, and D all had current statements, further review of their files found no evaluations from a health care provider (ARNP; physician; physician's assistant) verifying their freedom from signs/symptoms from other communicable . Interview with the administrator at approximately:30pm on indicated that no subsequent clinical evaluation had been obtained by any of these employees.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0081 Training - Staff In-Service

Based on record review and interview, two of three staff sampled (C; D) had not received all required training within 30 days of employment.

Findings include:

A personnel record review during the change of ownership survey revealed that neither Staff C and D, (hired) had any documentation verifying they had received training in the facility's elopement policies/procedures, while Staff C had no documented evidence of having received training in the reporting of major and adverse incidents. Interview with the administrator at approximately 1:25pm on indicated that some of this documentation had apparently been misfiled and was unavailable for inspection.

Class III

0090 Training -

Based on record review and interview, two of two staff sampled (C; D) had not received training regarding the facility's policies and procedures regarding within 30 days of employment.

Findings include:

A personnel record review during the change of ownership survey revealed that Staff C and D, both hired , did not have any documentation verifying they had received training regarding the facility's policies and procedure pertaining to . Interview with the administrator at approximately 1:40pm on / confirmed that no formal training had been provided.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
La Bella Vida ALF
7012 N Orleans Ave
Tampa, FL 33604

Dear Administrator:

This letter reports the findings of a change of ownership (CHOW) state licensure survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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/Fo .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(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida