STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969184	**10/20/2017**
NAME OF PROVIDER OR SUPPLIER **SEVILLA ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **12199 SW 51 ST** **MIAMI, FL 33175**	

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

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, record review, and interview, the Assisted Living Facility's Administrator failed to demonstrate that the Administrator was responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents. This is evident by having unknown and untrained person without eligible background screenings caring for a census of 12 residents. Which resulted in residents at the facility not having accurate medication records or proof that the medications were given.

Findings included:

1. Observation on at 9:40 AM revealed Staff D, E, and F were taking care of Residents #1, #4, #5 and #6. Staff E was in the kitchen cooking. The Administrator or the Assistant Administrator were at the facility upon arrival.

In an interview on at 9:49 AM Staff E and F stated, "I started yesterday". Staff E revealed that there were 6 residents.

Observation on at 9:50 AM revealed that there were two staff running around the pool with two residents in wheelchairs.

Observation on at 9:52 AM revealed that the house had an attached unit off the patio. The attached units had three , living a tablet and a big two toilets and two showers. There were medicines in the closet under the clothes. There were medicines separated in boxes with for Residents #7, #8, #9, #10, #11 and #12. There were three residents in the living attached unit, Residents #7, #12, and #11. There were two staff members taking care of residents, Staff H and I.

The Facility did not have personnel records for Staff E, F, H, and I including training documentation and eligible background screenings.

The background screening database revealed Staff E, F, H, and I did not have an eligible Level II Background Screening.

The Assistant Administrator arrived to the facility on at 10:15 AM. In an interview on at 10:52 AM the Assistant Administrator revealed the facility did not check the staff's background status. In a further interview on at 10:58 AM the Assistant Administrator stated, "they are new. We are on the process to get organized."

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The Administrator was asked to come to the facility for the exit. The Administrator arrived to the facility on 1:51 PM. The Administrator was not aware that multiple staff members did not have eligible background screenings and did not know the names of the staff members.

2. In an interview on at 9:54 AM Resident #9 revealed that lived in that placed for 2 years.

In an interview on at 9:56 AM Resident #10 revealed that lived in the facility.

The facility did not have MORs for Residents #3, #7, #8, #9, #10, #11 and #12.

In an interview on at 10:20 AM the Assistant Administrator revealed that there were no MORs for none of the residents living in the attached unit.

In an interview on at 2:02 PM the Assistant Administrator revealed that Resident #3 was admitted that previous week. Staff did not sign when Resident #3 took the medicines.

In an interview on at 2:05 PM the Assistant Administrator revealed Staff E and Staff G gave the medications to the residents.

Review of Staff G's personnel record revealed that there was no evidence of completion of medication training.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation and record review, the Assisted Living Facility failed to maintain accurate written work schedule that reflects its 24-hour staffing pattern for a given time period.

Findings included:

Observation on at 9:40 AM revealed Staff D, E, and F were taking care of Residents #1, #4, #5 and #6. Staff E was in the kitchen cooking.

Observation on at 9:52 AM revealed the house had an attached unit with residents living there off the patio. There were three residents in the living attached unit, Residents #7, #12, and #11.

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There were two staff members taking care of residents, Staff H and I.

Review of staffing scheduled revealed a posted staffing schedule from 2017. It showed that on Staff D and E worked from 7 AM to 7 PM and Staff A worked from 7 PM to 7 AM. It did not include Staff C, F, H, and I.

Class III

0120 - Fiscal - Financial Stability - 429.17(3) FS: 429.275(1)58A-5.021(1) FAC

Based on record review and interview, the Assisted Living Facility failed have income and expense records to show financial stability.

Findings included:

Record review revealed the facility did not have complete financial records for the last three months including income and expense records.

Exit interview on at 2:30 PM with the Administrator and the Assistant Administrator confirmed the financial records were not completed.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on observation, interview, and record review, the Assisted Living Facility failed to have personnel records for four out nine sampled staff (E, F, H and I).

Findings included:

Observation on at 9:40 AM revealed Staff D, E, and F were taking care of Residents #1, #4, #5 and #6. Staff E was in the kitchen cooking.

In an interview on at 9:49 AM Staff E stated, "I started yesterday".

In an interview on at 9:49 AM Staff F stated, "I started yesterday".

Observation on at 9:50 AM revealed that there were two staff running around the pool with two residents in wheelchairs.

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Observation on ..... at 9:52 AM revealed that the house had an attached unit off the patio. There were three residents in the living attached unit, Residents #7, #12, and #11. There were two staff members taking care of residents, Staff H and I.

The facility did not have personnel records for Staff E, F, H and I.

In an interview on ..... at 10:58 AM the Assistant Administrator stated, "they are new. We are on the process to get organized."

Class III

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

Based on observation, record review and interview, the Assisted Living Facility failed to have records for seven out of 20 sampled residents (#7, #8, #9, #10, #11, #12, and #13). The facility also failed to have complete records for 4 out of 20 sampled residents (#1, #3, #4, and #6).

Findings included:

Record review revealed Resident #1's record was not completed at the facility. Resident #1's contract and admission forms were not signed by the resident. Resident #1 had documents in the file that were white out by the facility.

Record review revealed Resident #3's record was not completed at the facility. Resident #3's contract was not signed and the facility did not have weights recorded for Resident #3.

Record review revealed Resident #4's family member signed the admission documents without having proof of a power of attorney, guardianship, or health surrogate.

Record review revealed Resident #6's record was not completed, the contact was not signed.

Exit interview on at 2:30 PM with the Administrator and the Assistant Administrator confirmed the resident records at the facility were not completed.

Observation on ..... at 9:52 AM revealed the house had an attached unit off the patio. The attached units had three , living a tablet and a big two toilets and two showers. There were medicines in the closet under the clothes. There were medicines separated in boxes with for

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Residents #7, #8, #9, #10, #11 and #12. There were three residents in the living attached unit, Residents #7, #12, and #11.

Observation on at 9:54 AM revealed that Resident #9 rested in bed.

In an interview on at 9:54 AM Resident #9 revealed that lived in that placed for 2 years.

In an interview on at 9:56 AM Resident #10 revealed that lived in the facility.

The facility did not have for Residents #7, #8, #9, #10, #11, #12 and #13.

In an interview on at 1:32 PM the Assistant Administrator revealed that Resident #13 was a respite resident. In further interview on at 1:58 PM the Assistant Administrator revealed that was unable to find the record.

Class III

0000 - Initial Comments

A complaint (CCR #2017007329) survey was conducted from , 2017 and concluded on , 2017. Sevilla Alf Llc with limited mental health component (license #13008), had the following deficiencies identified at the time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the Assisted Living Facility failed to have an updated health assessment for two out of 20 sampled residents (#5 and #6).

Findings included:

Record review revealed Resident #5's health assessment had not been updated.

Record review revealed Resident #6 was admitted to hospice. Record review revealed Resident #6's health assessment was not updated after the resident was admitted to hospice services.

Exit interview on at 2:30 PM with the Administrator and the Assistant Administrator confirmed the resident records at the facility were not completed.

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Class III

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

Based on record review and interview, the Assisted Living Facility failed to obtain medical care for one out of 20 sampled residents to prevent further (Resident #13). The facility did not contact the family or transfer the resident to the hospital for medical attention for two wounds that were observed on the resident's back. These factors contributed to the resident's wounds becoming , and the resident ultimately in the hospital.

Findings included:

A review of Resident #13's hospital record revealed that on the resident arrived to hospital with severe , (definition: the presence in tissues of harmful and their toxins, typically through of a). Resident #13 expires on . Resident #13's had a medical history of , , ( ), type II, and . Resident had contracted lower extremities. The resident had diagnoses of clinical , , , , acute lower , acute failure and hypernatremia and . On as per the resident's family, the resident stayed in the ALF while the family was on vacation for 6 days. When they returned, the family found the resident unresponsive, with a and took him immediately to the hospital. On arrival at the hospital, the resident was found , (low ,), had a high pulse (126), and had high , (45 breaths per minute). The resident had a high (temperature- 105.6 F). The resident was transferred to the ( ). The resident was dependent for several days while on the . The resident was extubated on . The resident's discharge date was from the hospital services and he was admitted under a hospice contracted bed.

In an interview on at 1:32 PM, the Assistant Administrator revealed Resident #13 was a 'respite' resident. In a further interview on at 1:58 PM the Assistant Administrator revealed he was unable to find the resident's record, and no record was provided.

During a phone interview with the Administrator on at 4:23 PM, she reiterated that Resident #13 was a 'respite resident.' She stated he was sick, and that he used a wheelchair but was not bedbound. She reported she had many residents, and she did not recall details about this resident. She further stated that Resident #13 did not have problems in the facility, as far as she knew, and that he had lived at the facility for 4 or 5 days. She stated that the facility contacted a doctor for Resident #13 regarding the and wounds, but that the doctor never came to see the resident. She further stated that the facility didn't follow up with the doctor, and the resident never received any medical care. The

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Administrator also reported that staff conducted rounds, depending on the residents' needs, every half hour or an hour. A review of facility records showed that there was no documentation of these rounds having been conducted. Further interviewed on at 4:38 PM, the Administrator reported she did not remember seeing Resident #13 at all, though she was informed that he did not feel well, but she still took no action. She stated that as far as she recalled, Resident (#13), starting having sores at the time of his arrival. The Administrator stated Resident #13 was not send to the hospital because he did not require it.

A review of facility records showed that there was no documentation or information regarding Resident #13.
Further review showed that the admission and discharge log listed Resident #13 as being admitted on and discharged on . The disposition on the admission/discharge log stated that Resident #13 "went home."

A review of the facility's policies and procedures showed that there were none regarding when and how respite or other residents should receive medical care, or about who was responsible for ensuring that residents received care.

While the facility was unable to provide a file or any documentation onsite about Resident #13, on at 5:24 PM the facility sent by email a respite care service agreement for Resident #13 extending from at 10:30 AM to to 7:30 PM. This service agreement was not signed by the client or the client's representative. Resident #13's service plan for respite revealed the resident would receive assistance with his wheelchair and other activities of daily living including bathing, dressing, toileting ( ), eating, , transferring, and receiving assistance with self-administration of medications.

On at 5:24 PM the facility also sent by email, progress notes which had not been available at the facility, dated , documenting that Resident #13 woke up with a of 99 degrees. These progress notes stated that facility staff had called a doctor, however there was no documentation that a doctor completed a face to face evaluation. The facility also documented that while bathing Resident #13, they noticed "2 sores, on and back butt area." The notes further stated that the unlicensed facility staff called the doctor, who instructed them to "put barrier cream" on the area. On , the staff documented "Resident #13 is not eating well." On , the facility documented "Resident #13 is eating with a lot of pressure, he refuses everything". On , the facility documented that Resident #13 was "sleepy." There was no documentation that Resident #13 was receiving any medical attention or care from to . No documentation was provided to show that staff conducted hourly rounds.

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Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interview, the Assisted Living Facility failed to have signed consents for the use of bed rails for two out of 20 sampled residents.

Findings included:

Record review revealed Residents #5 and #6 did not have signed consents for the use of bed rails.

Exit interview on at 2:30 PM with the Administrator and the Assistant Administrator confirmed the resident records at the facility were not completed.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the Assisted Living Facility failed to have Medication Observation Records (MORs) for six (#7, #8, #9, #10 #11 and #12) out of 14 sampled residents.

Findings included:

The facility did not have MORs for Residents #7, #8, #9, #10, #11 and #12.

In an interview on at 10:20 AM the Assistant Administrator revealed that there were no MORs for none of the residents living in the attached unit.

The facility also did not have MORs for Resident #3.

In an interview on at 2:02 PM the Assistant Administrator revealed that Resident #3 was admitted that previous week. Staff did not sign when Resident #3 took the medicines.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the Assisted Living Facility failed to keep medications secure at all

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times.

Findings included:

Observation on at 9:52 AM revealed there were medications in the closet of the attached unit under the clothes. The medications were separated in boxes with for Residents #7, #8, #9, #10, # 11, and #12.

In an interview on at 2 PM the Assistant Administrator revealed that facility stored their medications but Residents #8 and #10 were independent.

Observation at 12:20 PM revealed there were medications unsecured on the top shell of the hallway between kitchen and . Medications were: 2 bottles of Sol 10 gm/15 for Resident #15, 3 bottles of 10 gm/ 15 ml for Resident #15, 2% shampoo for Resident #16, 10 gm/ 15 ml for Resident #17, 10 gm/ 15 ml for Resident #18, Megestrol Ac Sus 40 mg/ml for Resident #19, drops for nails of Resident #12, Silver Sulfa Cre 1% for Resident #7, Oin 20% for Resident #20, one unlabeled bottle of Soothe (Subsalicytate 525 mg), one unlabeled of Milk of Magnesia, unlabeled anti- (, 2 mg).

In an interview on at 2:05 PM the Assistant Administrator confirmed that medications in the hallway between the kitchen and were unsecured.

Class III

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

Based on observation and interview, the Assisted Living Facility failed to ensure the Over the Counter (OTC) were labeled with the residents' names.

Findings included:

Observation at 10:16 AM revealed there were medications unlabeled in the medicine cabinet in the main kitchen. Medications were: stomach relief original formula pink liquid, (500 mg), anti- (, 2 mg).

Observation at 12:20 PM revealed there were medications unsecured and unlabeled on the top shell of the hallway between kitchen and . Medications were: one unlabeled bottle of Soothe

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(Subsalicytate 525 mg), one unlabeled of Milk of Magnesia, unlabeled anti- (2 mg).

In an interview on at 2:05 PM the Assistant Administrator confirmed that medications in the hallway between the kitchen and were unsecured. Also, some of medications did not have the names of residents labeled.

Class III

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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview, the Assisted Living Facility failed to have a signed attestation of compliance with background screening requirements in the employee's personnel file for Staff D.

Findings included:

Review of Staff D's personnel file revealed that the attestation of compliance with background screening requirements was not sign.

In an interview on at 2:50 PM the Assistant Administrator stated, "That's weird."

Unclassified

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that four (Staff E, F, H and I) out of nine sampled Staff Members had an eligible Level II Background Screening result prior to providing care to residents.

Findings included:

Observation on at 9:40 AM revealed Staff D, E, and F were taking care of Residents #1, #4, #5 and #6. Staff E was in the kitchen cooking.

In an interview on at 9:49 AM Staff E stated, "I started yesterday". Staff E revealed that there were 6 residents.

In an interview on at 9:49 AM Staff F stated, "I started yesterday". Staff also revealed that there were 6 residents.

Observation on at 9:50 AM revealed that there were two staff running around the pool with two residents in wheelchairs.

Observation on at 9:52 AM revealed that there were three residents in the living attached unit, Residents #7, #12, and #11. There were two staff members taking care of the residents, Staff H and I.

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In an interview on at 2:05 PM the Assistant Administrator revealed Staff E and Staff G gave the medications to the residents.

The Facility did not have personnel records for Staff E, F, H and I.

The background screening database revealed Staff E, F, H, and I did not have an eligible Level II Background Screening.

In an interview on at 10:52 AM the Assistant Administrator revealed the facility did not check the staff's background status. In a further interview on at 10:58 AM the Assistant Administrator stated, "they are new. We are on the process to get organized."

Unclassified.

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, record review, and interviews, the Assisted Living Facility exceeded licensed capacity of 6, the facility had a census of 12 residents and a day care participant.

Findings included:

Observation on at 9:40 AM revealed Staff D, E, and F were taking care of Residents #1, #4, #5 and #6.

In an interview on at 9:49 AM Staff E and F revealed that there were 6 residents.

Observation on at 9:50 AM revealed that there were two staff running around the pool with two residents in wheelchairs.

In an interview on at 9:50 AM Staff F revealed that did not know anything, Staff was new.
In an interview on at 9:50 AM Staff E revealed that did not know anything, Staff was new.
In an interview on at 9:50 AM Staff D revealed that did not know anything; Staff D worked privately taking care of Resident #1.

Observation on at 9:52 AM revealed that the house had an attached unit off the patio. The attached units had three , living a tablet and a big two toilets and two showers. There were medications in the closet under the clothes. There were medications separated in boxes with for Residents #7, #8, #9, #10, #11 and #12. There were three residents in the living

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attached unit, Residents #7, #12, and #11. There were two staff members taking care of the residents, Staff H and I.

The two resident that were previously observed in the pool area were, Residents # 11 and #12.

Observation on . . . . at 9:54 AM revealed that Resident #9 rested in bed.

In an interview on . . . . at 9:54 AM Resident #9 revealed that lived in that placed for 2 years.

In an interview on . . . . at 9:56 AM Resident #10 revealed that lived in the facility.

In an interview on . . . . at 11:10 AM the Assistant Administrator revealed that Residents #2 and #3 were at the program.

Unclassified