STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969184	R 11/27/2017
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)

0000 - Initial Comments

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

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

Based on observation, record review, and interview, the facility failed restrict the use of physical to half bed rails for two out of six sampled residents (#1 and 6). The facility failed to have signed consents for the use of bed rails for one out of six sampled residents (#5).

Findings included:

On at 9:10 A.M. observed in # , Resident #5's bed with full bed rails and Resident #6's beds with two half bed rails attached to one one side of the bed. Furthermore in # , Resident #1 had half bed rails at one side and a full bed rails attached to the other side of the bed.

During an interview on at 9:12 A.M. Staff D stated "we place the bed rails for safety, those resident move a lot in the bed and we preventing a ."

On at 9:56 A.M. Resident #1 stated, "I can remove one of the rails, the down one. But I cannot remove the other two. I want them to remove it all."

On at 10:56 A.M. the Administrator reviewed Resident #6's bed rails. He stated I'm going to remove it. Staff D assisted the Administrator in removing the additional half bed rail attached to the one side of the resident's bed.

Record review revealed the facility had a half bed rail order for Resident #6 dated . Record review revealed Residents #5 did not had signed consent for the use of bed rails.

Uncorrected Class III

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

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

Findings included:

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Observations on . . . . at 9:05 AM revealed Staff D and E were taking care of census of six residents and assisting them with activities of daily living (ADLs).

Review of staffing scheduled posted for (2017) revealed that on Staff D was scheduled to work from 7:00 A.M. to 7:00 P.M., Staff E was off, Staff J was scheduled to work from 7:00 A.M. to 7:00 P.M., and Staff A from 7:00 P.M. to 7:00 A.M.

During an interview on at 9:30 A.M., the Administrator stated Staff J does not worked here at the facility anymore since that last inspection. At 9:36 A.M. the Administrator reported Staff J is off. He reviewed staff scheduled and acknowledged that staff was scheduled to work on 11/ . He stated we did some changes.

Uncorrected 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 facility failed provide income and expense records to demonstrate financial stability.

Findings included:

Record review revealed the facility did not have complete financial records for the last three months. The facility did not have provide . . . . . 's income and expense records.

During an interview on . . . . at 11:55 A.M., the Administrator stated "we do paid our utilities online and I do not had record here."

Uncorrected Class III

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

Based on observation, record review and interview, the facility failed to have an updated health assessments for two out of six sampled residents (#3 and #4). The facility also failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for three out of six sampled residents (#3, #5, and #6).

Findings included:

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1) Observations on at 9:22 A.M. observe Staff D assisting Resident #3 with transferring, staff was holding the resident's hand.

Resident #3's health assessment dated revealed the resident was independent with all activities of daily living (ADL's).

Record review revealed Resident #4's health assessment dated showed the resident's nursing/ treatment/ services requirement as "Hospice." Resident #4 needed assistance with all activities of daily living (ADL) and puree diet.

During an interview on at 1:40 P.M., the Administrator stated Resident #4 did not received hospices care.

2) Review of Residents #4, #5, and #6's records revealed that family's member signed a resident consent to use the bed rails and facility documents without having proof of a power of attorney, guardianship, or health surrogate.

On at 1:50 P.M., the Administrator reviewed the residents' records to located the power of attorneys, the documentation was not found. He acknowledged the deficiencies found.

Uncorrected Class III

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

Based observations and record review, the facility failed to have the updated level 2 background screening on file for staff.

Findings included:

Observations on . . . at 9:22 A.M. observe Staff D assisting Resident #3 with transferring, staff was holding the resident's hand.

Record review revealed Staff D (caregiver) hired on background screening dated stated, "awaiting privacy policy." Review of the background screening database on . . . at 12:44 P.M. showed an updated status for staff.

Unclassified

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

Based on observation, record review, and interviews, the Facility failed to provide evidence that they did not exceed its licensed capacity.

Findings included:

On . . . . at 9:10 A.M. observed Staff D and E caring for a census of six residents, tour was conducted with Staff D that revealed that revealed that the house had an attached unit off the patio. In a previous survey was found that 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 attached unit, Residents #7, #12, and # 11. There were two staff members taking care of the residents. The facility Staff D and E did not give me access tour . . . . . unit.

During an interview on at 9:15 A.M., Staff D stated that part of the house had anything to do with the ALF "with us".

On . . . . at 10:06 A.M., the Administrator stated that area is a private house and is it separated from the ALF. He stated that part of the house is not included in the ALF flooring plan.

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On at 9:00 A.M. arrived at the facility to tour the unit, per Staff D and E they did not have keys to open the area.

During an interview on at 9:07 A.M., Staff D and E stated, "in that area no one leave, and we do not have the keys to give me access". Unable to tour the locked unit.

Observation on at 9:15 A.M. observed a white car drove away from the area. Per Staff D and E they don't know anything about that car.

Unclassified