STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967819	**01/08/2018**
NAME OF PROVIDER OR SUPPLIER **NUEVA VIDA ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1901 W OKALOOSA AVENUE** **TAMPA, FL 33604**	

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

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

Based on observation, interview and record review, the facility failed comply with the licensed capacity of six. Specifically, nine residents (Residents #1-9) received 24-hour assisted living services while the facility was licensed for a capacity of six residents.

Findings included:

Facility's license (#AL11800), effective from to , established that the facility was licensed for six private pay resident beds.

Upon facility entry, on at 06:20 a.m. Staff A, who worked the night shift stated that she worked at the facility for one week and the facility had nine residents who lived and slept at the facility. She stated that none of residents were independent and that she assisted with medication for all nine.

Facility tour, conducted with Staff A, on beginning at 6:30 AM revealed that the facility had two additional structures in the back of the facility, that were used for residents. A total six residents slept inside the licensed facility. Two residents slept in the left additional structure behind the licensed facility, and one slept in the right additional structure behind the licensed facility. Collectively the facility housed nine total residents.

During interview with the Interim Administrator, on at 06:45 a.m., she confirmed that nine residents slept at the facility; and confirmed that three of the facility's "day care" participants lived at the facility full-time, and once day care participant, Resident #4, was staying at the facility on a 24-hour basis while Resident #4's family traveled out of the area.

During interview with Staff B, on at 06:52 a.m., she stated that she worked at the facility for one year.
She stated that that facility had nine residents (6 assisted living, and 3 daycare participants); six slept in the main building and three lived in the additional structures. Staff B stated that she assisted all nine residents with medications, and the Administrator orders the medication for all nine. She identified Resident #9, who was observed sleeping in the employee , as a day care participant who has slept the facility on a 24-hour basiswhile family was out of town.

During interview with Staff C, on at 07:10 a.m., she stated that she worked at the facility for seven months. She confirmed that the facility has nine residents that sleep at the facility and reside at

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the facility full-time.

During interview with Resident #7, on at 07:37 a.m., he stated that he lived at the back left additional structure since . He stated that the Facility Employee assisted him with medication, and the Facility orders his medications. He stated that he was visited by the doctor, who visits the facility residents every month, and that the Administrator schedules the doctor visits and takes him to his doctor appointments.

On / 2017 at 08:00 a.m., Staff C was observed assisting Resident #7 with self-administration of medication.

During interview with the Interim Administrator, on at 08:22 a.m., she confirmed the three residents (#6, #7, and #8), who live in the additional structures behind the licensed facility, were seen by the facility doctor that visits monthly, and the facility manages their medication. She stated that she did not consider them as Assisted Living residents because they did not sleep in the main building . She confirmed that the additional structures in the back are built on the property of the Licensed Facility and shared the same address as the main licensed building.

On at 08:27 a.m., Staff C was observed assisting Resident #6 with self-administration of medication.

During interview with Resident #6, on at 08:27 a.m., he stated that Facility staff helped him with his medication. He stated that the Facility employees or the owner take him to his medical appointments. He stated that he has the same doctor that visits the Facility monthly, and the staff cleaned his do his laundry.

During Family interview for Resident #6, on at 08:58 a.m., he stated that Resident #6 lived at the facility for almost six years, and that he used to have a the main licensed building. The facility employees assist Resident #6 with his medication. The family member stated the Resident #6 was seen by the same doctor as all of the other resident in the facility. The Family member stated that Resident #6 was not an adult day care participant. He stated that the facility did not have a contract for Resident #6 and that he was referred to the Facility from the hospital.

During interview with Resident #9, on at 09:27 a.m., he stated that he has been at the facility for one week, while his family traveled. He stated that the Facility Staff assisted with his medication, bathing and changing.

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On at 09:37 a.m., Staff C was observed assisting Resident #9 with bathing and changing his clothes.

During family interview for Resident #9, on at 09:52 a.m., he confirmed that resident #9 has lived in the facility since .

On at 09:05 a.m. Staff C was observed assisting Resident #9 with self-administration of medication.

During family interview for Resident #7, on at 11:12 a.m., the family member stated that Resident #8 was an assisted living resident for almost one year. The family member stated that the facility manages and stores Resident #9's medications and assists him with the medication. She stated that Resident #7 was not a day care participant.

During family interview for Resident #8, on at 11:26 a.m., she stated that resident #8 was not a day care participant. She stated that the facility staff assisted his with bathing, dressing, and medications. They order all the medications with his doctor, who prescribe the medications. She stated that Resident #8 used to live in the main licensed building but was moved to the additional structure behind the licensed facility.

Review of the facility's Admission Discharge Log indicated that Resident#6 was listed as discharged to Independent Living on . There was no contract found in Resident #6's records.

Review of a health assessment (AHCA Form 1823), dated , for Resident #6, indicated that Resident #6 needed supervision with ambulation, handling financial affairs, preparing meals, and needed daily oversight that included observation for wellbeing, whereabouts and reminders of important tasks.

Record review revealed that Resident #7 has a contract for day care services dated . Health assessment (AHCA Form 1823), dated , for Resident #7, indicated that Resident #7 needed supervision with handling personal and financial affairs and Assistance with Self-administration of Medication. Further review revealed that the Administrator maintained Resident#7's physician orders and assisted with scheduling appointments, evidenced by hand written note in resident's record.

Review of the facility's Admission Discharge Log indicated that Resident #8 was discharged to" living by himself" on . Health assessment (AHCA Form 1823), dated , for Resident #7, indicated that Resident #7 needs supervision with ambulation, making phone calls, handling personal

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and financial affairs, and needed oversight that included daily observation for wellbeing, whereabouts and reminders of important tasks.

A Plan of Care reviewed and signed by the Case Manager on . . . . for Resident # 8 indicates that Resident #8 lived at the Facility and was unable to perform activities of daily living independently and establishes that the Facility was providing daily assistance.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

An unannounced complaint survey, (CCR# 2017012654), was conducted on , at Nueva Vida ALF, Inc., (License # 11800), an assisted living facility, located in Tampa, Florida. There were deficiencies identified during the survey.

(License # 11800)

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure that the resident health assessment (AHCA form 1823) included the date of examination, or the level of assistance required with medication for two (#5 and #8) of nine residents who resided at the facility.

Findings included:

Review of Resident #8's Health Assessment (AHCA Form 1823, dated) revealed that the assessment did not indicate the level of assistance that Resident #8 required with medications.

Review of Resident #5's health Assessment (AHCA Form 1823, dated) revealed that the assessment did not indicate the level of assistance that Resident #5 required with medications.

On at 11:43 a.m., the Interim administrator reviewed the health assessments for Residents #5 and Resident #8 and confirmed the level of assistance was not indicated. She also confirmed those were the most recent assessments she was able to find for the residents.

Class III

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

Based on observation and interview, the facility failed to ensure that one of five (Resident #4) residents sampled for observation while sleeping were free from physical .

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Findings included:

While conducting a tour of the facility with Staff A, on at 06:27 a.m., Resident #4 was observed in bed with a dresser on one side of the bed, while the other side of the bed was along the wall (image taken). Staff A stated that the dresser was moved against the bed to prevent Resident #4 from getting out of bed and falling.

During interview with the Interim Administrator, on at 10:40 a.m., she stated she did not know why Staff A would put the dresser against the bed and it may be to keep the resident from falling. She confirmed that there were no physician orders or instructions for the dresser to be used to prevent Resident #4 from getting out of bed.

Class III

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

Based on observation, and interview, the facility failed to ensure that centrally stored medication was kept in a locked receptacle. The refrigeration unit used for medication storage did not have a functional locking mechanism.

Findings included:

On at 07:29 a.m., a small refrigerator was observed next to the dining table. When opened the refrigerator was observed to contain medication; the refrigeration unit was not locked (image taken). The Interim Administrator was notified and confirmed observation. Neither Staff C nor the Interim Administrator could locate the key to lock to the refrigerator that is used to for medication storage.

On at 07:37 a.m., the Interim Administrator located the key, and attempted to lock the refrigerator. She confirmed that the locking mechanism would not lock. She stated that she will inform the Owner.

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Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log recording the admission and the discharge date, the reason for discharge, and where the resident was discharged for one (#5 and #6) of six resident who resided at the facility.

Findings included:

Facility tour conducted with Staff A, on , revealed that five residents slept in the main building and three residents (Residents #5, 6 and 8) slept in additional structures behind the facility on the facility property.

Review of the facility's Admission Discharge Log revealed that only four (#1, #2, #3, #4) residents were listed living in the facility. Further review revealed Resident #5 was not listed; Resident#6 was listed as discharged to Independent Living on ; and Resident #8 was listed as discharged to live by himself on .

During interview with Interim Administrator, on at 08:02 a.m., she reviewed th Admission Discharge Log and confirmed that Resident #5 was missing from the log. She stated that Resident #8 is a resident whose son travels for work, and identified Resident #5, Resident #7, and Resident #8 as residents who lived in the additional structure behind the Licensed Facility.

On at 09:15 a.m., Interim Administrator stated that she was not able to find any log of Admission Discharge for the additional residents.

Class III