STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969184	**02/01/2019**
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)

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observations, record review, and interview the facility failed to have an updated employee roster in the background screening database for eight of 14 sampled staff (Staff E, F, I, J, K, L, M, and N).

Findings included:

1) On [redacted] at 5:20 AM arrived at the facility and entered at 5:35 AM. Staff L and M falsely identified themselves as Staff C and D. During the survey on [redacted] at 11:15 AM, Staff C and D arrived, both staff members provide evidence of identification for verification.

Record review found Staff L and M were not listed on the employee roster.

2) Further observations on [redacted] at 5:45 AM, found Staff I and K working in the [redacted] unit of the facility with residents. Staff J was observed in a car attempting to move Residents #3 and #4.

Further record review found the facility did not have Staff I, K, and J listed on the roster.

3) Record review found the facility did not update Staff E and F's status on the roster.

The administrator revealed during the survey both staff members stopped working on [redacted].

4) Resident interviews revealed the facility had another staff member that was around the resident, the driver, Staff N.

On [redacted] at 11:45 AM the Administrator confirmed Staff N was responsible on taking the residents to doctor's [redacted] and he stated: "it was true, he is not in the roster." Staff N was left alone with the residents and transported them to the doctor's [redacted]."

Unclassified

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

Based on observation, record review, and interview, the facility failed to have an eligible level II background screening for five of 14 sampled staff prior to staff providing direct care and services to residents (Staff I, K, L, M, and N).

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Findings included:

1) On at 5:20 AM arrived at the facility and entered at 5:35 AM. Staff L and M falsely identified themselves as Staff C and D. During the survey on at 11:15 AM, Staff C and D arrived, both staff members provide evidence of identification for verification. Staff L and M were in the facility with six residents and one daycare residents.

On at 5:35 AM Staff L reported to be working with Staff M. They stated that there were 6 residents and 1 daycare client who just arrived to the facility. Staff L and M could not provide any source of identification during the survey. Personnel records found the facility did not have files for Staff L and M including eligible level 2 background screenings.

2) Further observations on at 5:45 AM, found Staff I and K working in the unit of the facility with residents (#3 and #4).

On at 7:50 AM, Staff I reported she was taking care of at least four residents in the unit. Identification (ID) was requested to both staff members (I and K). Staff I provided a passport. Staff K stated he had to go and look for his ID and never came .

Further record review found the facility did not have personnel records including eligible level 2 background screenings for Staff I and K.

3) Resident interviews revealed the facility had another staff member that was around the residents, the driver, Staff N.

On at 11:45 AM the Administrator confirmed Staff N was responsible on taking the residents to doctor's and he stated: "it was true, he is not in the roster." Staff N was left alone with the residents and transported them to the doctor's ."

Personnel record review found the facility did not have personnel records including eligible level 2 background screenings for Staff N.

Unclassified

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

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Based on observation, record review and interview, the facility exceeded licensed capacity of six by maintaining a census of 10 residents and one daycare resident. The facility has a capacity of 6 beds.

Findings included:

1) On at 5:20 AM arrived at the facility and entered at 5:35 AM. Staff L and M falsely identified themselves as Staff C and D. Staff L and M could not provide any source of identification during the survey. During the survey on at 11:15 AM, Staff C and D arrived, both staff members provide evidence of identification for verification. Staff L and M were in the facility with six residents and one daycare residents.

On at 5:35 AM Staff L reported to be working with Staff M. They stated that there were 6 residents and 1 daycare client (Resident #11) who just arrived to the facility. Resident #11 was admitted on . The resident had three set of pill organizers for multiple days was observed in a lunch box with clothing. The adult day care agreement stated, client shall be dropped off at 9:00 AM and picked up by 9:00 PM.

2) On at 5:45 AM tour reflected additional rooms at the rear of the facility. While attempting to gain access to the area, observed lights on in two rooms where two unidentified persons lying in two beds. A gray curly short haired woman (Resident #1) sleeping next to the window (refer to photographic evidence). There appear to be someone in the bed next to her (Resident #2). There was another room with beds that appeared to have something or someone on them (refer to photographic evidence). The side door was locked and unable to open.

On at 7:45 AM, observed two staff members and two residents in the unit. The whereabouts of Resident #1 and #2 were unknown.

On at 7:50 AM, according to Staff I, another dark blue car took the resident observed by the window and stated that the owners would come in the morning to give the medications. She reported she was taking care of at least four residents in the unit.

On at 8:15 AM, Resident #3 stated she had been living in that place for a few months already and that she had a son that did not come to see her. She got her medication, food and care sometimes by the same staff that work in the facility and for her medication, a man used to come every day at night to provide it. The facility did not have records available for the resident.

On at 9:00 AM, Resident #4 stated, "I will tell you the truth, I signed a contract with the

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administrator. The contract was signed like three weeks ago and I was staying in the room by the garage area and today early in the morning, even though it was very , they moved me from my bed to the other side." Tour of the facility found, the garage was converted into two separate makeshift rooms with beds furnished and women belongings observed. Local temperature was around 50 degrees. The facility did not have records available for the resident. In a conversation, the administrator and Resident #4 revealed she had been at the facility after being discharged from the hospital. The monthly agreement was $2300 per month and she had paid a portion of this to say in a space in the garage. The administrator stated he was going to give Resident #4 a refund (copy of the check provided).

Unclassified

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0000 - Initial Comments

A standard biennial survey was conducted in conjunction with a complaint survey at Sevilla ALF LLC with Limited Mental Health component on , , and concluded on , , . Deficient practice was identified during the survey.

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on observation, record review, and interview, the facility failed be under the supervision of an administrator who 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 allowing five of 14 sampled staff, who were unknown and untrained persons without eligible background screenings, First Aid and , , , ( ) training in the facility with 10 residents and 1 day-care resident ( ). The facility who is licensed for six beds was overcapacity, four of 11 residents were living in the unit of the facility and the garage (Residents #) which placed the residents in imminent danger.

Findings included:

1. On at 5:20 AM arrived at the facility, the iron fenced was locked with a chain link around the property. A small doorbell was found in a small box, rang it a few times and finally Staff L came out of the front door and was told the purpose of the survey. Staff L stated she was going inside to get the key but did not return. A called was place to the facility's phone number at 5:31 AM, no one answered. At 5:33 AM, a phone call was received from an unidentified phone number, the woman stated she was going to contact the staff at the facility so they could give access to the property. The door was finally answered at 5:35 AM. The facility had four rooms with six residents and a male, identified as daycare participant was found in shorts sitting in the dining room (Outside temperature was around 50 degrees). Staff L and M falsely identified themselves as Staff C and D. Staff L and M could not provide any source of identification during the survey. During the survey on at 11:15 AM, Staff C and D arrived, both staff members provide evidence of identification for verification.

On at 5:35 AM Staff L reported to be working with Staff M. They stated that there were 6 residents and 1 daycare client who just arrived to the facility. Personnel records found the facility did not have files for Staff L and M.

On at 5:50 AM the administrator arrived to the facility, shortly after Staff L and M left the facility.
On at 7:20 AM the administrator stated that Staff L and M left without him noticing and he did

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not know where they were. He stated he was going to call them to return to the facility but there was no evidence that he actually called them.

On at 11:41 AM, further interview with the administrator revealed he did not have personnel records for Staff L and M, who were left alone with the residents. He confirmed that both staff members did not have a completed background screening, First Aid and ( ) training, medication, food safety, or control training.

On at 6:45 AM, observed Staff H (who worked at Granada ALF) arrive to the facility. On at 9:00 AM an additional interview with Staff H revealed, "I worked in another facility but the administrator called me this morning to let me know that I needed to come here because the other caregivers had to leave."

Medication pass observations on at 9:20 AM found Staff H assisting Resident #9 with medications. She initialed all medications prescribed for 8:00 AM prior to observing the resident take the medication and outside of the one hour window. Then, Staff H took the small container with medications which included , Divalproez, Citalpram, and to the resident with a cup of water. packet was not given to the resident, who noticed and mentioned it to the staff. Staff H looked for the packet and dissolved it in water and gave it to the resident. At 10:42 AM, the staff stated, "I am trained, I have all my training; I have the medication training." Staff H's last medication training was for 2 hours and was dated not the initial 4 hours of medication training.

The following resident needed assistance with activities of daily living in the facility:

Resident #5 was admitted on , Health assessment dated documented had unsteady gait and required assistance with most of the activities of daily living.

Resident #6 was admitted on , Health Assessment dated documented unsteady gait and that the resident required assistance with most of the activities of daily living.

Resident #7 was admitted on , Health assessment dated documented the resident has unsteady gait, memory and concentration decline, and precautions. The resident required assistance with most of the activities of daily living.

Resident #8 was admitted on , Health assessment dated documented the resident has unsteady gait, decreased memory, precautions, and required assistance with all activities of daily

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living (pure/ soft mechanical) plus assistance with self-administration of medications.

Resident #9 was admitted on , Health assessment dated documented the resident has unsteady gait, is an elopement risk, and required assistance with self-administration of medications.

Resident #10 was admitted on , Health assessment dated documented the resident has unsteady gait, decrease memory, and required assistance with all activities of daily living plus assistance with self-administration of medications.

Resident #11 was admitted on (daycare) The resident had three set of pill organizers for multiple days was observed in a lunch box with clothing. The adult day care agreement stated, client shall be dropped off at 9:00 AM and picked up by 9:00 PM.

2. On at 5:45 AM tour reflected additional rooms at the rear of the facility which are not part of the licensed assisted living Facility. While attempting to gain access to the area, observed lights on in two rooms where two unidentified persons lying in two beds. A gray curly short haired woman sleeping next to the window (refer to photographic evidence). There appear to be someone in the bed next to her (Resident #1 and #2). There was another room with beds that appeared to have something or someone on them (refer to photographic evidence). The side door was locked and unable to open.

According to administrator on at 5:50 AM, this part of the property did not belong to the facility and he did not had a key to open the door. He stated, "We have nothing to do with that area. That area is rented by the owners of the property." The surveyors requested access again and the administrator stated he was going to call the owner for the keys. Later he told us that the owner was going to send someone with the keys; that the owner was in Cuba.

On at 7:45 AM, a car drove to the left side of facility. According to the administrator, the driver of the car was his ex-wife bringing paperwork which was requested. The car drove to the . Observations found the car was waiting to move residents from the unit. The side door was open; a woman (Staff I) was taking out a basket of clothes and behind her, a male staff, who identified himself as Staff K was pushing a wheel chair with a woman. The woman identified herself as Resident #3; behind her, another resident identified as Resident #4. The car drove off. Further observations at 7:45 AM, found only Residents #3 and #4 were still present in the unit. The whereabouts of the two individuals that were previously observed were unknown.

On at 7:50 AM, according to Staff I, another dark blue car took the resident observed by the

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window and stated that the owners would come in the morning to give the medications. She reported she was taking care of at least four residents in the unit. Identification (ID) was requested to both staff members. Staff I provided a passport. Staff K stated he had to go and look for his ID and never came .

On at 7:50 AM further interview with Staff I revealed she did not have documents stated that she had been working in the facility only for one week and that she came from Cuba on was living in Jacksonville until last week and she needed to make some extra money and she went through the newspaper to find this job. A gentleman called her and told her that if she wanted to start working immediately and that he was going to come to the facility at the end of this week to pay me because I am going to Cuba by the end of , or beginning of ,.

On at 8:15 AM, Resident #3 stated she had been living in that place for a few months already and that she had a son that did not come to see her. She got her medication, food and care sometimes by the same staff that work in the facility and for her medication, a man used to come every day at night to provide it. The facility did not have records available for the resident.

The health assessment (dated) for Resident #3. The medical history and diagnoses , (,,), , , and (, . Resident #3 had unsteady gait, required precautions, and needed supervision with most of the activities of daily living.

On at 9:00 AM, Resident #4 came around the front of the facility to and stated that she was going to leave. Resident #4 stated she had signed the contract with them. The administrator stated he did not know Resident #3 and that she never signed a contract with him, then Resident #4 walked out the front door. Moments later, Resident #4 came inside of the facility and stated, "I will tell you the truth, I signed a contract with the administrator. The contract was signed like three weeks ago and I was staying in the room by the garage area and today early in the morning, even though it was very , they moved me from my bed to the other side." Tour of the facility found, the garage was converted into two separate makeshift rooms with beds furnished and women belongings observed. Local temperature was around 50 degrees. Facility did not have records available for the resident. In a conversation, the administrator and Resident #4 revealed she had been at the facility after being discharged from the hospital. The monthly agreement was $2300 per month and she had paid a portion of this to say in a space in the garage. The administrator stated he was going to give Resident #4 a refund (copy of the check provided).

Hospital records received on for Resident #4 dated had chief complaint- Depressed, off medications, forgetting things, , . to . Patient discussed with

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coordinator for voluntary admission, seen by psychiatrist and restarted on medication. Diagnoses: right and history of . Admission on revealed patient needs assistance with activities of daily living. Signs of moderate is present. Discharged summary had diagnoses of major recurrent moderate. Notes: Follow up in one week; instructed to take medications as prescribed and informed about potential side effects.

3. Personnel record review revealed Staff I, J, K, L M, and N did not have eligible level 2 background screenings, employment applications or the required training and documentation to work in an Assisted Living Facility such as: pre-service orientation training, control, Activity of Daily Living (ADL) and behavioral needs training, Elopement response, reporting major incidents, reporting averse incidents, facility emergency procedures, incident report training, resident right and recognizing/reporting /neglected training, nutritional and safe food handling, / training, do-not- order ( ) P&P training, First aid training, ( ) training, medication training and Limited Mental Health (LMH) training.

On at 11:41 AM the administrator stated that he did not have the documents for Staff I, K, L, and M. He knew that what he did was incorrect but with reference to Staff I he had nothing to do with her even though she was taking care of other four residents on the side of the same facility despite the evidence that was found during the survey.

During record review was revealed that the facility had another staff member that were around the resident, the driver, Staff N.

On at 11:45 AM the Administrator confirmed that staff N was responsible on taking the residents to doctor's and he stated: "it was true, he is not in the roster." Staff N was left alone with the residents and transported them to the doctor's ."

4) The administrator failed to ensure that facility records were updated including medication records, financial records, insurance and inspection records.

Class I

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

Based on observation, record review, and interview, the facility failed to have trained and qualified staff members on site at all times to care for and provide supervision appropriate to the scheduled and

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unscheduled service needs of the residents at all times for 10 of 10 sampled residents and one daycare resident (Residents). The facility is licensed for six beds. The facility placed all the residents in imminent danger by having four staff individuals working in the facility around adults. The facility was unable to provide any documentation that the individuals observed in the facility were actually who they said they were because when identification was requested three out of four left the facility and were not seen again.

Findings included:

Cross reference to A 077. The facility failed be under the direction of an administrator who responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents.

1. On at 5:20 AM arrived at the facility. The licensed facility door was finally answered at 5:35 AM. Staff L and M falsely identified themselves as Staff C and D. Staff L and M could not provide any source of identification during the survey. During the survey on at 11:15 AM, Staff C and D arrived, both staff members provide evidence of identification for verification.

On at 5:35 AM Staff L reported to be working with Staff M. They stated that there were 6 residents and 1 daycare client who just arrived to the facility. Personnel records found the facility did not have files for Staff L and M which included a completed background screening, First Aid and ( ) training, medication, food safety, or control training.

On at 5:50 AM the administrator arrived to the facility, shortly after Staff L and M left the facility. On at 7:20 AM the administrator stated that Staff L and M left without him noticing and he did not know where they were. He stated he was going to call them to return to the facility but there was no evidence that he actually called them.

2. On at 5:45 AM tour reflected additional rooms at the rear of the facility which are not part of the licensed assisted living Facility. While attempting to gain access to the area, observed lights on in two rooms where two unidentified persons lying in two beds. A gray curly short haired woman sleeping next to the window (refer to photographic evidence). There appear to be someone in the bed next to her. There was another room with beds that appeared to have something or someone on them (refer to photographic evidence). The side door was locked and unable to open.

Further observations on at 7:45 AM, found only Residents #3 and #4 were still present in the unit. The whereabouts of the two individuals that were previously observed were unknown.

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On at 7:50 AM, according to Staff I, another dark blue car took the resident observed by the window and stated that the owners would come in the morning to give the medications. She reported she was taking care of at least four residents in the unit. Identification (ID) was requested to both staff members. Staff I provided a passport. Staff K stated he had to go and look for his ID and never came .

On at 7:50 AM further interview with Staff I revealed she did not have documents stated that she had been working in the facility only for one week and that she came from Cuba on was living in Jacksonville until last week and she needed to make some extra money and she went through the newspaper to find this job. A gentleman called her and told her that if she wanted to start working immediately and that he was going to come to the facility at the end of this week to pay me because I am going to Cuba by the end of , or beginning of .

On at 8:15 AM, Resident #3 stated she had been living in that place for a few months already. She got her medication, food and care sometimes by the same staff that work in the facility and for her medication, a man used to come every day at night to provide it. The facility did not have records available for the resident.

On at 9:00 AM, Resident #4 stated, "I will tell you the truth, I signed a contract with the administrator. The contract was signed like three weeks ago and I was staying in the room by the garage area and today early in the morning, even though it was very , they moved me from my bed to the other side." Tour of the facility found, the garage was converted into two separate makeshift rooms with beds furnished and women belongings observed. Local temperature was around 50 degrees. Facility did not have records available for the resident. In a conversation, the administrator and Resident #4 revealed she had been at the facility after being discharged from the hospital. The monthly agreement was $2300 per month and she had paid a portion of this to say in a space in the garage. The administrator stated he was going to give Resident #4 a refund (copy of the check provided).

3. Personnel record review revealed of Staff I, J, K, L M, and N did not have eligible level 2 background screenings, employment applications or the required training and documentation to work in an Assisted Living Facility such as: preservice orientation training, control, Activity of Daily Living (ADL) and behavioral needs training, Elopement response, reporting major incidents, reporting averse incidents, facility emergency procedures, incident report training, resident right and recognizing/reporting /neglected training, nutritional and safe food handling, / training, do-not- order ( ) P&P training, First aid training, , , ( ) training, medication training and Limited Mental Health (LMH) training.

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On at 11:41 AM the administrator stated that he did not have the documents for Staff I, K, L, and M. He knew that what he did was incorrect but with reference to Staff I he had nothing to do with her even though she was taking care of other four residents on the side of the same facility despite the evidence that was found during the survey.

Resident interviews revealed the facility had another staff member that were around the resident, the driver, Staff N.

On at 11:45 AM the Administrator confirmed that staff N was responsible on taking the residents to doctor's and he stated: "it was true, he is not in the roster." Staff N was left alone with the residents and transported them to the doctor's ."

Class I

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review, and interview, the facility failed to have a generator onsite and policies and procedures available for review regarding the emergency environmental control.

Findings included:

On at 6:50 AM, observed the facility without a generator.

The Administrator stated, "We had a problem with the generator and we had to take it. It works with both, gasoline and propane."

Review of the facility finder in the system showed an implementation date of . Review of the facility's records showed the facility did not have policy and procedures. The administrator acknowledged the policy and procedures were not available.

Class III