STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966481	**01/31/2019**
NAME OF PROVIDER OR SUPPLIER **ALF SEVILLA HOME CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **8331 SW 27 ST** **MIAMI, FL 33155**	

SUMMARY STATEMENT OF DEFICIENCIES
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Z824 - Right of Inspection; Inspection Reports - 408.811 FS; 59A-35.120 FAC

Based on observation and interview, the facility failed to provide timely access to the facility for an unannounced compliance inspection.

Findings included:

On at 4:50 AM arrived to the facility rang the doorbell, observed a male (Staff B) opened a house door that lead to a porch, then to the locked bar door and stated that he needed to get dressed.

On at 5:10 AM, Staff B stated he could not open the porch bar door because he could not find the key.

On at 5:13 AM observed Staff B was able to obtained the keys to grant access to the facility.

Unclassified

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

Based on observation and interview the facility failed to operate within their licensed capacity. The facility's licensed capacity was for 6 beds, however 9 Residents were found to be living at the facility.

Findings Included:

On at 5: 28 AM, Surveyors observed 9 Residents living at the facility.

On at 5:28 AM, the Administrator stated she had a census of 9 residents. She acknowledged she was over capacity. She stated she knew it was wrong and she did it because of financial hardship.

Unclassified

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0000 - Initial Comments

A Standard survey, in conjunction with a complaint investigation (CCR#2019000123) survey, conducted on and concluded on . Alf Sevilla Home Care Dream , had the following deficiencies identified at the time of the survey:

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

Based on observation, record review and interview, the facility failed to provide care and services appropriate to adequately meet the needs of residents in care. Resident had a and sustained an injury to the that resulted in a hematoma (Resident #1). Resident # 3 had a that resulted in a . The facility failed to provide written records of the incidents that required medical services for 2 out 10 sampled residents. (Resident #1 and # 3). The facility failed to provide evidence of sufficient staff employed at the facility to provide care and services for 9 residents.

Findings Included:

1)On at 7:41 AM observed Resident #1 sitting at the dining room table with a discolored, black, and red puffy area just below the right . Resident #5 stated Resident #1 . Staff B and the Administrator stated Resident #1 had two days earlier.

On at 7:45 AM the Administrator stated "It happened last week, while he was sitting by the front porch. She said Resident #1 was with a family member that was visiting him. Resident #1 tried to get up and he tripped and forward. She further stated "No we did not call the emergency department because he appeared okay and he did not lose his or anything like that." The Administrator stated she did not document or report the incident. Observation on at around 1:00 pm showed that Resident #1 was transported to the hospital via ambulance initiated by the Department of Children and Families.

A review of Resident #1's record showed the resident was admitted . The health assessment on file dated showed medical history and diagnoses: , high , , , , and prostatic hyperplasia. Physical or sensory limitations: Needs Assistance. or Behavioral Status: Awake, alert, oriented x 2. Nursing/Treatment/ Service Requirements: As needed. Special Precautions, per health assessment the resident had precautions and is not an elopement. The health assessment did not indicate the type of assistance the resident needed with activities of daily living. There was no documentation of the resident falling and sustained an injury in file. There was no documentation the

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had been reported to the physician.

A review of Resident #1's hospital record from the admission showed: Presenting Complaint: Emergency medical services states: This is a male coming into emergency department for injury. Patient down 2 days ago. History of present illness/Subjective Patient is an male with past medical history: high , and who presented to the emergency department following a injury 2 days ago. Patient from an upright position and sustained injury to the resulting in a hematoma in the right periorbital region. He also sustained and . Patient presented with and incomprehensible speech. While in the Emergency department he was found to have a and an abnormal . Patient is a poor historian to his vs recent .

2) A review of Resident #3's Hospital Record, documented the resident was admitted to the hospital on , arriving at the hospital due to status post with left . Patient was alert, oriented to person with lapses of in place and time. Per patient report she felt , and without loss of . The record further stated "At this moment left in immobile and is rotated externally. Patient has good , refill and , is 3 in a scale of . Patient has past medical history of , high , , and . Patient denies , vomits, , and or , . Patient admitted, and taken to surgery and had ORIF (is a type of surgery used to fix broken bones).
Findings: Acute sub capital left with varus angulation of the line and , displacement of the shaft. No .
Acute sub capital of the left , . There is slight , migration of the shaft. "

On at 10:12 AM the Administrator stated that she did not have a health assessment or any written records of Resident # 3 . She stated the resident suffered the in the beginning of at the facility.

Class 1

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation, record review, and interview, the facility failed to treat residents with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. The facility failed to provide care and services appropriate to adequately meet the needs of residents in care. The facility failed to provide a safe and decent living environment, free from and

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neglect (Resident #2). Resident # 2 was in a room that was locked from the outside, and also reported mistreatment from a staff member. The facility failed to maintain freedom from for 1 out 10 sampled residents (Resident #10). The resident had a ½ side bed rail in the center of the bed and that was not prescribed by a physician.

Findings Included:

1) On at 7:41 AM observed Resident #1 sitting at the dining room table with a discolored, black, and red puffy area just below the right . Resident #5 stated the resident . Staff B and the Administrator stated Resident #1 two days ago. At 7:45 AM the Administrator stated "It happened last week, while he was sitting by the front porch. Resident #1 was with a family member that was visiting him. Resident #1 tried to get up and he tripped and forward. No, we did not call the emergency department because he appeared okay and he did not lose his or anything like that."

2) On at 5:15 am, observed a door leading from resident #2's room to the yard. The door was locked from the outside, and when asked, Resident #2 stated that he was unable to unlock the door. At 5:50 AM, Resident #2 requested to speak privately. Resident #2 stated "Please help me, the guy that works here treats me very bad. I feel bad being here. He humiliates me and kicks the door by saying that, if I lock it he will knock the door down. He speaks very rude to me and I feel very bad. He doesn't let me go to the bathroom and when I am in the bathroom he will go in. No, he has never hit me but he is very rude. This place is hell, please take me with you. Do not leave without getting me out of here. You can call my daughter."

On at 5:30 AM, observed the only entry and exit from Resident # 7 and #8 room was through Resident #2 room, and did not allow any privacy to the residents. Resident #2's room did not have a closet.

On at 9:10 AM, the Administrator stated she did not know there was no closet in Resident #2's room. She also stated she would fixed the issue to give Residents # 2, #7, and #8 privacy.

3) On at 5:20 AM observed Resident #10 lying in bed. Observed ½ side rail in the center of the bed preventing resident from exiting the bed.

Review of Resident #10 file showed no documentation that a physician gave order for the side rail.

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4) On at 5:35 AM Resident # 4 stated Resident #5 was moved to room three that day, shortly before the inspection began. Resident # 4 stated Resident #5 belonged in a another room. Resident # 5 stated she did not know why she was moved to room three. She stated "the guy just told me to move here for now."

On at 8:56 AM at Staff B stated Resident #5 was moved to another room temporarily but he did not give a reason or give the resident notice that she was moving to another room.

Class II

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

Based on observation and interview, the facility failed to properly dispose of medications for 2 out 12 sampled residents (Resident # #12). The facility failed to keep over the counter medications in a secure place out of sight of 9 out of 12 sampled residents.

Findings Included:

On at 5:22 AM, observed in two separate cabinets in Resident #2 room stored prescribed medications, 20 mg tablet,Linsinopril 40 mg. tablet, , 20 mg. tablet and , 30 mg. capsules for Resident # 3. Observed prescribed medications, SOD Dr 40 mg. tablet, 12.5 mg, , Low 81 mg. tablet, 20 mg. tablet for Resident # 12. Resident #3 and # 12 had been discharged from the facility.

On at 5:20 AM, observed unsecured over the counter medications, Barrier , Peri Guard ,Aloe Vesta,Protective ,Diaper A&D , , Reliever 500 mg, Tears,and in Residents #2, #4, and #5 rooms. The medications were accessible to all residents.

On at 9:10 AM, Staff B stated the prescribed and over the counter medications belonged to the residents that occupied the rooms.

On at 9:10 AM, the Administrator stated several of the prescribed medications belonged to residents that were discharged from the facility. She stated the prescribed medications to be returned to the pharmacy.

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Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, record review and interview the facility failed to follow the posted menu. The substitutions were not noted before or when the meal was served.

Findings Included:

1) On during facility tour from 5:13 AM to 6:45 AM observed the refrigerators and food cabinets had locks placed on them. The residents were not able to gain access for snacks during the night.

On at 8:56 AM, Staff B stated some of the residents open the refrigerator and removed food items and dropped food on the floor.

2) On at 6:30 AM, observed Resident #6 eating breakfast and the meal to include eggs which was not listed on the menu.

At 7:15 AM observed Residents #2, #5,#7,and # 8 with eggs on their plates.

On a review of the facility breakfast menu did not show eggs was listed as a substitution.

On at 7:20 AM, Staff B stated Resident # 6 requested the eggs and he decided to serve the other residents eggs.

Class III

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

Based on record review and interview, the facility failed to have an up to date admission and discharge log.

Findings Included:

On a review of the facility's admission and discharge log revealed, Resident #1 was admitted on , Resident #7 was admitted on , Resident #5 was admitted on , Resident #4 was admitted on , Resident #6 was admitted on , Resident #2 was

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admitted on . . . . . The log did not list Resident #3, #8, #9, #10, #11, and #12.

On a review of facility records revealed Resident #11 was admitted on , and there was a closed records for Resident #12 with a health assessment dated .

On at 8:40 AM the Administrator stated that Resident #11 was there for less than a month and he left with his family. The Administrator informed that Resident #3 lived in the facility in the beginning on , but was sent to the hospital due to a .

Class III

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

Based on record review and interview, the facility failed to maintain resident records on the premises for 2 out of 12 sampled residents. (Residents # 3 and #10)

Findings include:

On review of facility records showed there were no files for Residents # 3 and # 10 at the facility.

On at 8:40 AM, the Administrator stated she did not have files for Resident # 3 and #10. She stated she probably had the files at her home.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to have a copy of its approved Comprehensive Emergency Management Plan (CEMP).

Findings Included:

Record review showed no documentation of the facility's approved CEMP.

On at 10:34 AM, the Administrator stated she did not have the CEMP approval letter.

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Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and interview the facility failed to develop and implement written policies and procedures to ensure that it can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The facility also failed to notify each resident and the resident's legal representative in writing about its Emergency Power Plan (EPP). In addition, the facility did not have a copy of its approved emergency power plan letter.

Findings Included:

A review of the facility's record on showed no documentation of an approved emergency power plan and a written EPP policies and procedures that were readily available for a review. The facility did not have a detailed plan to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power.

On at 10:34 AM, Staff B stated there was no fuel on site.

On at 10:34 AM, the Administrator stated she was aware of not having the Emergency Policy & Procedures, the approved EPP letter and letters informing the resident and families of the Emergency Power Plan.

Class III