STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968775	R **05/30/2019**
NAME OF PROVIDER OR SUPPLIER **LA VIDA EN EL MAR ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6802 ROSEWOOD CT** **TAMPA, FL 33615**	

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

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on interview and record review, the facility failed to ensure that 5 out of 5 sampled employees (Owner, Administrator, Staff A, Staff B, Staff D) had a signed compliance attestation form for background screening in their employee file.

Findings included:

On a record review was conducted of the Owner. The Owner did not have a signed compliance attestation form in his employee file.

On a record review was conducted of the Administrator. The Administrator did not have a signed compliance attestation form in her employee file.

On a record review was conducted of Staff A. Staff A did not have a signed compliance attestation form in her employee file.

On a record review was conducted of Staff B. Staff B did not have a signed compliance attestation form in her employee file.

On a record review was conducted of Staff D. Staff D did not have a signed compliance attestation form in his employee file.

During an interview with the Administrator on she stated, "Whatever I have in there is what I have, so it's not in there."

Unclassified

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

Based on interview and record review, the facility failed to honor resident rights to provide a safe living environment free from . Specifically, the facility failed to address verbal and risk of , to 9 of 9 residents (Residents #2, 3 4, 5, 6, 7, 8, 9 and 10), failed to follow their own policy, including training staff on detection and reporting and failed to prevent employees without eligible background screens from having contact with residents of the facility.

Findings Included:

On at 7:15AM Resident #8 was interviewed and stated, "A staff member slapped a resident. I was taking up for the resident and got into an altercation with the staff. It was (Resident #5) who got slapped. (Staff B) yells at us. I do not want to live here, but I do not want to get kicked out. They do not like us asking for food. I do not like living here, I do not feel safe here."

On at 07:50AM, Resident # 2 was interviewed and stated, "The staff yells at me. He (The Owner) draws to hit me but never has." Resident #2 was interviewed again at 12:30PM and stated, "(Staff E) is a night girl and she is mean."

On at 7:54AM Resident #9 was interviewed and stated that the staff yell at him sometimes.

On at 8:00AM Resident #6 was interviewed and stated, "The staff yell at me over medication. I complained the medication was making me feel bad and giving me a . They yelled at me and said the medication was right. I am not sure if I like living here yet. They keep getting onto (Resident #5) because he uses the restroom on himself. He cannot hold it and they yell at him for it."

On at 10:36AM Resident #7 was interviewed and stated, "I do not like (Staff E), she is mean." Resident #7 was interviewed again at 12:43PM and stated that Staff E is "cruel and mean."

On at 11:07am Resident #5 was interviewed and stated, "Yes, I have been slapped in the (The Owner) hit me."

On , a record review of a local hospital's Hospitalist History and Physical Report (HPR) dated revealed Resident #1 was dropped off to a local Emergency Room (ER) by the Facility staff. According to the records, Resident #1 stated to the ER physician that he was whipped by a staff member at the Facility (photographic evidence). Further review of the HPR revealed that records from

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another local hospital revealed that Resident #1was discharged from the hospital to the Facility with the Owner listed as the contact.

During an interview with Staff B on at 10:16AM she stated, "(Resident #1) was at the Facility for one day and went to (a local hospital). He had . I was here alone and I called the Owner and he came and called 911."

During an interview with the Administrator on at 11:18AM she stated, "On (the Owner) admitted (Resident #1) from (a local hospital). I came to see him the same day, I saw his health assessment. He had and , . He was yelling that he was having a . I noticed he was agitated, he wanted attention. I told him he was fine, his , was ok. I left (the Owner) here with him and the contract to sign. The same night he went to the hospital. Our friend took him to the hospital and as soon as she parked he jumped out."

During the survey on , Staff A was observed working in the facility from 6:20 AM to 7:44 AM.

A review of Staff A's employee file on revealed there was no documentation of an eligible Level II background screening.

During a tour of the facility conducted with the Administrator on at 6:35AM, Staff E was observed hiding in an upstairs closet in a nightgown. The closet also contained unsecured discharged resident medication. The Administrator asked Staff E, "Who are you?"

An attempted record review of employee records on revealed Staff E did not have an employee file.

A record review of the Background Screening portal on revealed that Staff A and Staff E did not have an eligible Level II background screenings.

A record review of the Facility's policy was conducted on at 11:54AM (photographic evidence). The policy stated the following: "The administrator will oversee the training of new staff to detect the signs of resident as well as the appropriate reporting protocol. All employees will complete a criminal background check, a drug test and two reference checks before hire. In-service training on prevention, detection and reporting will be provided at least annually to staff."

Staff E had not completed required in-service training on and Staff A and Staff E did not have documentation of eligible background screenings.

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Class I

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to provide evidence of freedom from ( ) documented on an annual basis for four (The Administrator, Staff A, Staff B, and Staff D) of five employees records reviewed.

Findings included:

A record review of the Administrator's employee record on revealed the Administrator had no evidence of a negative examination in their personnel file.

A record review of the Staff A's employee record on revealed Staff A had no evidence of a negative examination in their personnel file.

A record review of Staff B's employee record on revealed the Staff B had no evidence of a negative examination in their personnel file.

A record review of Staff D's employee record on revealed Staff D had no evidence of a negative examination in their personnel file.

During an interview with the Administrator on at 8:48AM the Administrator stated, "Whatever I have in there is what I have, so it's not in there."

Class III

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0000 - Initial Comments

A revisit survey was conducted in conjunction with a complaint survey (Complaint Number 2019008282) at La Vida En El Mar Assisted Living Facility on - . La Vida En El Mar Assisted Living Facility had deficient practice identified at the time of the survey.

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

Based on observations, interview and record review, the facility failed to ensure one of nine sampled residents (Resident #6) was appropriate for continued residency at the facility, and that one (Resident #5) of nine Residents had a -to- medical examination by a healthcare provider after a significant change.

Findings included:

During an interview with a Hospice Employee on at 7:47AM she stated, "I am here to bathe (Resident #5)."

A review of Resident #5's resident record on revealed he was admitted to hospice on (photographic evidence). Further review of Resident #5's record revealed his latest Resident Health Assessment was dated and that he was independent with bathing.

During an interview with the Administrator on at 11:18AM she stated, "Resident #5 is not independent, hospice comes to bathe him. I need a new 1823 (Resident Health Assessment)."

A record review of Resident #6's Resident Health Assessment revealed that she was total care with ambulation. The Resident Health Assessment was not dated (photographic evidence).

Resident #6 was observed throughout the survey on using a wheelchair for ambulation.

During an interview with Resident #6 on at 12:39PM she stated, "I can't walk that well, I can only take a few steps."

During an interview with the Administrator on at 11:18AM, she stated, "I did not know Resident #6 was total care".

Class III

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