STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968775	**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)

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

Based on observation, record review, and interview the facility failed to ensure that two of two sampled staff (Staff A and Staff E) who worked and slept at the facility and provided direct care to residents had eligible Level II background screens, allowing them to be around residents and provide care to adults.

Findings Included:

During the survey on between 06:20AM and 07:44 AM Staff A was observed in the facility preparing breakfast for the residents. Staff A was also observed taking a key out of her pocket and unlocking the resident's secured medication.

A record review of Staff A's employee file on revealed Staff A, with a hire date of , did not have documentation of an eligible Level II background screening.

During an interview with the Administrator on at 8:31AM, the Administrator stated, "I do not have her prints." The Administrator also indicated she did not have Staff A's social security number required to initiate a background screen.

On at 06:35AM Staff E was observed in a pink nightgown, hiding in the upstairs closet of the facility, with unsecured discharged resident medication.

On at 6:35 AM, an interview was conducted with Staff E. Staff E stated she was a friend of the Owner and needed a place to sleep, so she slept on the couch of the facility.

On at 07:44AM Staff A was interviewed and stated, "(Staff E) slept on the couch because I did not feel good and my hurt. She is my cousin."

A record review of the employee files 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 eligible Level II background screenings.

On at 07:50AM, Resident # 2 was interviewed and stated, "(Staff E) is a night girl and she is mean."

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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."

Class II

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0000 - Initial Comments

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

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

Based on record review, interview and observation, the facility failed to ensure that a qualified Administrator, who had completed the training and testing requirements, provided required oversight of the facility, including ensuring residents were cared for by qualified staff, adhering to the facility's licensed capacity of six and providing necessary care and services for nine of nine sampled residents (Residents #2-#10).

Findings Included:

Record review conducted on revealed the Administrator who was responsible for the day-to-day operations of the facility, had completed core training on but had no record of having taken the core competency test.
During an interview with the Administrator conducted on at 8:48am, the Administrator confirmed she had not taken the test and stated she would be scheduling the core competency test in .

Record review conducted on revealed two (Staff A and Staff E) out of seven staff did not have an eligible Level II Background Screening. Staff A and Staff E were observed in the facility from 6:20AM-7:44AM. Staff A was observed in the kitchen preparing breakfast. Staff E was observed hiding in an upstairs closet with resident medication.

Record review conducted on revealed five (Owner, Staff A, Staff B, Staff D and Staff E) out of seven staff did not have assistance with self-administration of medication training required to assist residents with self-administration of medication. Further record review of the Medication Order Reports (MORs) conducted on revealed the MORs were signed off by the Owner, Staff A, Staff B, and Staff D, none of whom had training on assistance with self-administration of medication. At 8:06AM Staff B was observed assisting with self-administration of medication with the Administrator present.

Observation during the tour conducted on a7 07:35AM revealed there was a census of 9

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residents receiving assisted living services, including assistance with medication, while the facility has a licensed capacity of 6.
A record review of FloridaHealthfinder on revealed the Facility was previously cited for operating over capacity on .

During an interview with the Administrator conducted on beginning at 11:18am, the Administrator stated they were aware staff were assisting with self-administration of medication and did not have the required training and they confirmed there was no Level II Background Screening for Staff A and Staff E.

On a follow-up visit to facility on at 12:32PM Staff B was observed administering medication to Resident #5. Staff C, whose record review on revealed assistance with self-administration of medication training, was present.

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."
A record review of the Facility's admission discharge log on revealed Resident #1 was not listed.

On an attempt was made to review Resident #1's record, however there was no record at the facility for this resident.

Class II

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

Based on observation, interview and record review the Assisted Living Facility failed to ensure qualified staff were available to provide resident supervision and services to meet the resident's overall needs prior to the survey date and after being notified by the Agency. Furthermore, the Assisted Living Facility failed to ensure at least one staff member with valid First Aid and , , ( ) certifications was in the facility at all times. The Assisted Living Facility's noncompliance and failure to have qualified staff on duty placed all residents (give identifiers) at imminent risk of harm.

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Findings Included:

During the survey on , , Staff A was observed working in the facility from 6:20 AM to 7:44AM and Staff E was observed hiding in an upstairs closet with resident medication at approximately 07:35AM.

On , , at 6:35 AM, an interview was conducted with Staff E. Staff E stated she was a friend of the Owner and needed a place to sleep, so she slept on the couch. An attempted record review of the employee file on , , revealed Staff E did not to have an employee file, any of the required trainings, or a valid background screening.

On at 07:50AM, Resident # 2 was interviewed and stated, "(Staff E) is a night girl and she is mean."
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 6:20 AM, an interview was conducted with Staff A. Staff A stated she had worked at the facility for a month. Staff A was observed with keys to locked medication cabinets in her pocket. Staff A removed keys from her pocket and was observed unlocking cabinets in the kitchen and in resident rooms to reveal where the resident's medications were stored.

On , , a review of Staff A's employee file revealed Staff A was hired on , , . There was no verification or documentation that Staff A had the required training in assistance with self-administration of medication, First Aid, or ; and no documentation of a freedom from statement, background screening compliance attestation or a valid background screening prior to having direct contact with residents, resident's personal spaces and belongings.

On , , at 8:06 AM, Staff B was observed assisting Resident # 2 with medications with the Administrator also present. At 8:18 AM Staff B was observed retrieving from the refrigerator, dialing the , and injecting Resident # 5 with . When asked about the administration, Staff B stated, "I always do the ."

On , , , a review of Staff B's employee file revealed Staff B was hired on , , . There was no documentation in Staff B's employee file indicating that Staff B had the required assistance with self-administration of medication training, valid First Aid and training or an attestation of compliance related to the background screening requirements.

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On , , at 9:10 AM, an interview was completed with the Administrator regarding the staff qualifications and training documentation. The Administrator stated, "Whatever I have in there is what I have, so it's not in there."

On , , at 9:18 AM, the Administrator left the facility, leaving Staff B alone at the facility with the residents.

On , , at 10:16 AM, Staff B confirmed through interview that she was working at the facility alone on , when Resident #1 had a medical episode. Staff B stated she had to call the Owner, the Owner came to the facility, called 911 and Resident #1 was taken to the hospital.

On , , a record review of the local hospital;s Hospitalist History and Physical Report dated revealed Resident #1 was dropped off at at local Emergency Room (ER) by the Facility staff. The patient (Resident #1) stated to the ER physician that he was whipped by a staff member and reported , and in the past 30 minutes (photographic evidence).

On , , at 12:32 PM, during continued survey at the facility, Staff B who was previously identified as not having medication training was observed administering Resident # 5's . Although Staff C, whose record review on revealed assistance with self-administration of medication training, was present in the facility at the time, Staff B was observed donning gloves, cleaning the resident's arm with an , , pricking the resident's and performing a test with a . After obtaining the reading of 349, Staff B was observed rolling the , between her , dialing the resident's , and injecting the medication into the resident's arm. When asked about the process, Staff B stated, "I am going to inject it, not (Resident # 5)".

Class I