Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953233	A. BUILDING: _____ B. WING _____	08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA SERENA II	60-62 NW 33 AVENUE MIAMI, FL 33125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ815 SS=D	408.809; 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ␣ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ␣ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ␣ , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The	CZ815		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ815	Continued From page 1 qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (h) Section 817.234, relating to false and fraudulent insurance claims. (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (k) Section 817.505, relating to patient brokering. (l) Section 817.568, relating to criminal use of personal identification information.	CZ815		

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CZ815	Continued From page 2 (m) Section 817.60, relating to obtaining a credit card through fraudulent means. (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (o) Section 831.01, relating to forgery. (p) Section 831.02, relating to uttering forged instruments. (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (s) Section 831.30, relating to fraud in obtaining medicinal drugs. (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (u) Section 895.03, relating to racketeering and collection of unlawful debts. (v) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee as of , and was screened and qualified under ss. 435.03 and 435.04, has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) A person who serves as a controlling interest	CZ815		

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CZ815	Continued From page 3 of, is employed by, or contracts with a licensee on , , , who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by , , , in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be: (a) Individuals for whom the last screening was conducted on or before , , must be rescreened by , , . (b) Individuals for whom the last screening conducted was between , , , and , , must be rescreened by , , . (c) Individuals for whom the last screening conducted was between , , , through , , must be rescreened by , , . (6) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening.	CZ815		

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CZ815	Continued From page 4 (7)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (8) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining [illegible] pursuant to s. 943.05(2). (9) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial	CZ815		

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CZ815	Continued From page 5 or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required	CZ815		

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CZ815	Continued From page 6 unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , , if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all staff personnel who have access to client funds,	CZ815		

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CZ815	Continued From page 7 personal property, or living areas had an eligible background screening level 2 for one out of eight sampled staff (Staff E). Finding included: Observation on [redacted] at 12:08 PM showed that there were some maintenance tools outside of Residents #10 and #11's room. There was an electronic miter saw on the kitchen next to the sliding door. During an interview on [redacted] at 12:16 PM, Staff B stated that Staff D and E did maintenance jobs at the facility but they also worked on the others facilities owned by the same owner. Staff D and E moved between facilities as needed. Review of background screening database showed that Staff E completed a background screening level 2 on [redacted] and the results showed "not eligible". Unclassified	CZ815		

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A 193 SS=D	59AER20-4 Mandatory Testing for Assisted Living Facilit (1) APPLICABILITY. The requirements of this emergency rule apply to all assisted living facilities licensed under Chapter 429, F.S. (2) DEFINITIONS. "Staff" means all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or materials, including body substances (e.g., , tissue, and specific ,); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. Staff may include, but are not limited to, nurses, nursing assistants, physicians, technicians, , , , , pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons (e.g., clerical, dietary, environmental services, laundry, security, maintenance, engineering and facilities management, administrative, billing, and volunteer personnel) not directly involved in patient care but potentially exposed to agents that can be transmitted among from staff and patients. This definition is consistent with the Centers for Control and Prevention definition of Healthcare personnel as defined in Appendix 2. , (3) MANDATORY STAFF TESTING FOR COVID-19. (a) Beginning , , assisted living facilities shall not admit into the facility any staff who has not been tested for COVID-19. (b) Assisted living facilities shall require all staff be tested every two (2) weeks thereafter with testing resources provided by the state. (4) EXEMPTION FROM TESTING. Staff who have already been and recovered from COVID-19 do not need to be	A 193		

AHCA Form 3020-0001

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A 193	Continued From page 1 tested if they can provide medical documentation to the assisted living facility. (5) DOCUMENTATION. (a) If testing is conducted off-site, then staff must provide proof of testing to the assisted living facility. (b) Assisted living facilities shall document all staff testing, including the name of the individual, time, and date of the test. (c) Assisted living facilities shall require all tested staff to notify the facility of the test results the same day the results are received. Written documentation of test results must be provided to the facility upon receipt by the staff. (d) Assisted living facilities shall keep copies of all staff testing documentation on site. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including but not limited to, license revocation, license suspension, and the imposition of administrative fines. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to deny the access into the building to any staff who did not have evidence of being tested for COVID-19. Findings included: During an interview on . . . . . at 1:05 PM, Staff B stated that Residents #1 and #7 received nursing services from at least three different nurses of two different home health agencies. The regular assigned home health agency nurse [Registered Nurse (RN)_A]for Resident #1 had a sick family member and a different nurse (RN_B)provided services to him. Staff B stated	A 193		

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A 193	Continued From page 2 that there was no documentation for the nurses COVID-19's tests. During an interview on at 4:49 PM, RN_B stated not providing services to Resident #1 on Saturday or Sunday (and). The home health agency sent a different nurse during those days. During an interview on at 12:16 PM, Staff B stated that Staff E did maintenance jobs at the facility. Review of the facility's record showed that there was no documentation of the COVID-19 tests for the home health agencies' nurses or Staff E. Class III	A 193		
A 000	Initial Comments A COVID-19 and Generator monitoring survey was conducted at Villa Serena II on through . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the	A 025		

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A 025	Continued From page 3 facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain updated written record	A 025		

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A 025	Continued From page 4 indicating residents new illness and the contacts completed to the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager for 11 out of 15 residents sampled (Residents #1, #2, #3, #4, #7, #8, #9, #10, #11, #13 and #15). Findings included: During an interview on . . . . . at 11:33 AM, Staff B stated the facility transferred two residents to a local hospital. The staff added that there were nine residents who tested positive to COVID-19. On a further interview on . . . . . at 11:47 AM, Staff B stated Resident #4 was at the hospital since the previous afternoon (. . . . .) because he did not want to eat and had . . . . . During additional interviews on . . . . . between 11:47 AM and 12:13 PM Staff C stated that Residents #1, #2, #3, #4, #7, #8, #9, #10, #11, and #15 tested positive to COVID-19. Review of Resident #4's record showed that there was no documentation indicating that the facility informed his health care provider or the resident's family, guardian, health care surrogate, or case manager about the resident being at the hospital or testing positive to COVID-19. Review of Residents COVID-19 test results showed that the laboratory detected COVID-19 for Residents #1, #3, #4, #7, #9, #11. During an interview on at 12:02 PM, Staff B stated the facility sent Resident #13 to a local hospital on . The resident was at	A 025		

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A 025	Continued From page 5 the facility for 5 days and started shaking and with . The hospital informed later to the facility that Resident #13 tested positive to COVID-19. Review of Resident #13's record showed that there was no documentation indicating that the facility informed his health care provider or the resident's family, guardian, health care surrogate, or case manager about the resident being at the hospital or testing positive to COVID-19. Review of Residents #1, #2, #3, #7, #8, #9, #10, #11and #15's record showed that there was no documentation indicating that the facility informed their health care providers or the residents' family, guardian, health care surrogate, or case manager about the residents' new illness. During an interview on . . . . . at 1:33 PM, the administrator stated she contacted the residents' health care providers and family members or guardians but she was not sure if those contacts were documented. Class III	A 025		
A 030 SS=J	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953233	A. BUILDING: _____ B. WING _____	08/11/2020

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VILLA SERENA II	60-62 NW 33 AVENUE MIAMI, FL 33125

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A 030	Continued From page 6 (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers.	A 030		

Agency for Health Care Administration

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A 030	Continued From page 7 (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.	A 030		

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A 030	Continued From page 8 (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this	A 030		

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A 030	Continued From page 9 paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , , , , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , , and prohibitions set forth in this part is posted in a	A 030		

Agency for Health Care Administration

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A 030	Continued From page 10	A 030		

prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and, if applicable, ... , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . , ... or . . , ... under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall

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VILLA SERENA II	60-62 NW 33 AVENUE MIAMI, FL 33125

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A 030	Continued From page 11 such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to safeguard 15 out of 15 sampled residents from exposure to COVID-19, a potentially life-threatening illness caused by exposure to Coronavirus (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14 and #15). The facility had 10 positive COVID-19 residents (Residents #1, #2, #3, #4, #7, #8, #9, #10, #11, and #15) who were not [illegible] in the facility, plus two residents (Residents #4 and #13) who were hospitalized with symptoms of COVID-19. The facility's staff who were positive for COVID-19 provided care and services to positive and negative COVID-19 residents, and those staff members did not wear appropriate Personal Protective Equipment (PPE) to prevent cross- . Findings included: The COVID-19 is a transmissible , , [illegible] that presents severe risk to persons who are aged, infirm, or suffer from co- including, but not limited to, [illegible] system deficiency, , , [illegible], and [illegible]. See generally, Publications of the Centers for [illegible] Control. On , the Governor of the State of Florida issued Executive Order 20-51 designating a Public Health Emergency as a result of	A 030		

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A 030	Continued From page 12 COVID-19 and its impact. Pursuant to that authority, emergency orders have been issued by the Florida Division of Emergency Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizens, including those most to the effects of . The Agency for Health Care Administration (AHCA) has issued guidance and clarification on DEM Order 20-006 to providers, and on , issued an alert notifying all homes that all staff or other individuals admitted to a residential facility must don masks and that caregivers must wear gloves when providing resident care. While the treatment and management of residents with and the implementation of isolation precautions for such events are a long-standing health care issues faced by residential facilities, the ease of contagion and the effects of presented by COVID-19 mandate that providers exert meticulous practice and procedure to identify resident symptoms and take immediate procedures to both assure appropriate treatment of a potentially resident and protect the remainder of a facility's population from the risk of spread of the . A review of recommendations from the Centers for Control (CDC) dated showed that if COVID-19 was identified or suspected in a resident of an Assisted Living Facility, the residents should immediately be in their room and the health department notified. The recommendations further stated that, "For situations where close contact between any (, or ,) resident cannot be , personnel should at a minimum, wear protection (goggles or	A 030		

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A 030	Continued From page 13 shield) and an N95 or higher-level , (or a facemask if , are not available or personnel are not fit tested). Cloth coverings are not PPE and should not be used when a , or facemask is indicated. If personnel have direct contact with the resident, they should also wear gloves. If available, gowns are also recommended but should be prioritized for activities where splashes or sprays are , or high-contact resident-care activities that provide opportunities for transfer to , to and clothing of personnel (e.g., , bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, care). On at 8:00 a.m. upon entering the facility Staff B greeted state representatives (surveyors), and after being asked, she stated she had tested positive for COVID-19 on , and for three to four days and then returned to work per facility administrator's instruction. She had not been tested again to confirm whether or not she was still positive prior to returning to work. Staff B was observed not wearing proper Personal Protective Equipment (PPE); she was only wearing a surgical mask and medical uniform. Staff B also mentioned that Staff C was assisting residents with self-administration of medication and preparing and serving breakfast to residents. She stated that residents who were positive and negative with COVID-19 shared the same dining table. On at 8:00 a.m. observation showed that Staff B was providing care to residents that were both positive and negative of COVID-19. Further observation revealed Staff C, who had	A 030		

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A 030	Continued From page 14 also tested positive for COVID-19, was providing care to residents. Despite Staff B and Staff C both being positive for COVID-19, they were providing assistance with activities of daily living (ADL) such as bathing, grooming, meal preparation and assistance with self-administration of medications. During the survey residents were observed not maintaining social distancing of at least 6 . . . apart, and were not wearing any PPE. On at 8:05 a.m. Staff B stated she knew there were residents who had tested positive for COVID-19, but did not know which residents. Staff B also said that there was no documentation in residents' files identifying which resident had tested positive since the results had not been received yet. Staff B admitted that even though she had provided assistance to the residents, she did not know which ones were positive with COVID-19. On . . . . . at 9:05 a.m. COVID-19 test results were received via fax. Review of these records revealed that the "result" portion of the tests had been blocked out. Further review of the records indicated that there was no way to confirm which residents were positive or negative with COVID-19. On . . . . . at 9:05 a.m. during telephone interview with administrator, she stated that the COVID-19 "results" portion of the test were blocked out due to how they were submitted by the State Health Department. In addition, the administrator said that residents who tested positive had been . . . . . ; she was not able to identify those residents. On at approximately 09:45 AM, a Home	A 030		

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A 030	Continued From page 15 Health Agency Registered arrived at the facility to administer the morning to Resident #1. During the screening process, Staff B informed the nurse that the resident was COVID-19 positive. The nurse stated he did not know beforehand that the resident was positive. He told Staff B that he needed to call his home health agency about the situation, and he then proceeded to leave the facility. The nurse was only wearing a facemask. Observation on at 11:33 AM showed that Staff B opened the facility's door wearing a blue disposable facemask and gloves. During an interview on at 11:33 AM, Staff B stated the facility's census was of 15 residents but two of them were out to the hospital. The staff added that nine residents at the facility and the two staff members on duty tested positive to COVID-19. On a further interview, on at 11:51 AM, Staff B stated that she wore a shield when bathing the residents. She stated that she she used gown when she had to provide first aid care if someone , and during baths. Observation on at 12:58 PM showed Staff B put on a shield. Observation on at 11:39 AM showed that there were three shields inside the staff room and two packages of 50 units each of blue disposable masks. There was one box of 100 gloves in the living room. On a further observation at 1:03 PM, there was one box with an original quantity of 100 gloves less than half full, on the wall next to the kitchen. During an interview on at 1:03 PM, Staff C stated she didn't know where more gloves	A 030		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA SERENA II	60-62 NW 33 AVENUE MIAMI, FL 33125

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A 030	Continued From page 16 were. Review of Residents COVID-19 test results showed that the laboratory detected COVID-19 for Residents #1, #3, #4, #7, #9, #11 on . Review of Resident #1's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of , ( ), ( ) type II, and . Review of Resident #1's COVID-19 test result showed he tested positive on . Review of Resident #2's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of , , Non- , and . The resident required precautions. Review of Resident #2's COVID-19 test result showed he tested positive on . Review of Resident #3's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of , GEARED ( ), and ( ). Review of Resident #3's COVID-19 test result showed he tested positive on . Review of Resident #4's record showed that according to his health assessment (AHCA form	A 030		

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A 030	Continued From page 17 1823) completed on unknown date, he had the medical and diagnoses of , severe (,) and , . Review of Resident #4's COVID-19 test result showed he tested positive on . Review of Resident #5's COVID-19 test result showed he tested negative on . Review of Resident #6's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of , , , , and . The resident required precautions. Review of Resident #6's COVID-19 test result showed he tested negative on . Review of Resident #7's record showed that according to his health assessment (AHCA form 1823) he had the medical and diagnoses of cutaneous B-cell lymphoma, , ( ), of , legally . Right embolic , and , The resident who received three times a week, needed assistance with ambulation, bathing, , and transferring. Review of Resident #7's COVID-19 test result showed he tested positive on . Review of Resident #8's record showed that according to his health assessment (AHCA form 1823) completed on , the resident had medical history and diagnoses of , , , and	A 030		

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A 030	Continued From page 18 . Resident #8 who required assistance with self-administration of medication suffered of behavior changes and loss of memory. The resident tested positive to COVID-19 on . Review of Resident #8's COVID-19 test result showed he tested positive on . Review of Resident #9's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of acute , and . The resident required total care for bathing and and supervision for ambulation, eating, self-care and toileting. Review of Resident #9's COVID-19 test result showed he tested positive on . Review of Resident #10's COVID-19 test result showed he tested positive on . Review of Resident #11's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of , , , , and . Review of Resident #11's COVID-19 test result showed he tested positive on . Review of Resident #12's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of , , , , circumstantial , and insight limited. Review of Resident #12's COVID-19 test result	A 030		

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VILLA SERENA II	60-62 NW 33 AVENUE MIAMI, FL 33125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 19 showed he tested negative on . Review of Resident #13's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of major , , type 2 , history of use , . Review of Resident #14's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of with , Major , , , history of , impulse control , , and right side , , required precautions. Review of Resident #14's COVID-19 test result showed he tested negative on . Review of Resident #15's record showed that according to his health assessment (AHCA form 1823) completed on , he had the medical and diagnoses of with (Prostatic Hyperplasia), , , , , and , , . Review of Resident #15's COVID-19 test result showed he tested positive on . 2. During an interview on at 11:36 AM, Staff B stated Residents #5, #6, #12, and #14 tested negative to COVID-19. The staff added that the facility's staff members helped Resident #12 and #14 with bathing and medications and Residents #6 received assistance with self-administration of medications. Resident #5 was an independent living resident and the	A 030		

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A 030	Continued From page 20 facility's staff members cooked and served his food. On a further interview at 11:39 AM, Staff B stated that Staff B and C provided care and services to all the residents as they needed plus assisting everyone with their medications. Observation on at 11:33 AM and 11:52 AM showed Resident #2 walking down the hallway from the of the facility to # while wearing a mask covering his and . Observation on at 12:03 PM showed Residents #9 and #12 sat less than 6 apart from each other on TV room while they watched TV. Resident #9 did not wear a mask and exposed his and while Resident #12 wore a mask that covered his mouthy and . Review of Residents COVID-19 test results showed that the laboratory detected COVID-19 for Resident #9 on . During an interview on at 11:38 AM, Staff B stated the facility's staff members did their best to bathrooms after someone used it. At 11:50 AM, Staff B added that the positive and negative residents and staff members shared the same bathrooms. Observation on at 11:52 AM showed Resident #5 walking in one of the bathrooms across from # . Further observation showed that Resident #5 exited from the bathroom on at 11:53 AM. Staff B emptied into the toilet a half-full that the resident had brought, then rinsed the in the sink. Further observation revealed that no one cleaned or the bathroom after the	A 030		

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A 030	Continued From page 21 resident used it. Staff B was not observed changing her gloves or washing her . Staff B continued walking throughout the facility with visitors while Staff C was on the kitchen area. During an interview on at 11:54 AM, Staff B stated Residents #6 and #7 used to share # . Residents #5 and #6 tested negative to COVID-19 while Resident #7 tested positive to COVID-19 during the last round of tests. The facility decided to leave Resident #7 sleeping along in # while Resident #6 starting to share # with Resident #5 during sleeping time. Resident #6's personal belongings remained in the room occupied by Resident #7. Staff B collected what Resident #6 needed and brought them to his new sleeping room. During an interview on at 12:21 PM, Staff B stated that Staff F gave her the COVID-19. Staff F informed to Staff B that the method of transmission of COVID-19 was thru the saliva and contact. On a further interview on at 12:29 PM, Staff B added that she had runny and body , around one week before she has the COVID-19 test done but she continued working. At 1:07 PM, Staff B added she knew being positive to COVID-19 on a Sunday and did not work the following Monday, Tuesday and Wednesday staring to work on Thursday. On a further interview on at 3:31 PM, Staff B stated she returned to worked after three days off because the facility's administrator called her and asked her to return to work. The staff did not see her doctor (health care provider) after testing positive to COVID-19. Staff B stated not having a negative COVID-19 test after the positive. Staff B stated she checked the residents' temperature. The staff did not feel comfortable delegating the temperature check on Staff C because Staff C	A 030		

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A 030	Continued From page 22 was new working at the facility. Staff B revealed that the administrator and Staff F provided her . . . . . control training and COVID-19 training. She was instructed that someone had a the temperature was 40 or higher degrees Celsius or 104 or higher degrees Fahrenheit. During an interview on at 12:23 PM, Staff C stated she knew and learned from the television news about what to check for on the residents as possible symptoms of COVID-19. The staff started to work at the facility around . . . . . and had a negative COVID-19 test at that time. Her duties included to prepare and serve food and make the laundry and housekeeping to the residents and the independent living residents. Staff C added that she assisted all the residents with self-assistance administration at bedtime and with ambulation and transferring as needed. The staff was extremely tired around . . . . . while working at the facility; it was around one week before the facility tested the staff for COVID-19. The staff said that she continued working and caring for the residents at the facility while she felt sick. During a further interview on at 3:34 PM, Staff C stated she did not work for approximately four days after finding out that tested positive to COVID-19. She said that after that Staff H called Staff C asking her to return to work because the facility did not have staff. Staff C further stated that she felt extremely tired during the interview. During an interview on at 1:05 PM, Staff B stated that Residents #1 and #7 received nursing services from at least three different nurses of two different home health agencies. Staff B further stated that the regularly assigned home health agency nurse [Registered Nurse (RN)_A] for Resident #1 had a sick family	A 030		

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A 030	Continued From page 23 member and a different nurse (RN_B) provided services to him. Review of facility's records showed that there was no documentation indicating the facility screened any of those nurses after . During an interview on at 11:47 AM, Staff B stated the facility sent Resident #4 to a local hospital the previous afternoon ( ) because the resident did not want to eat and had . At 12:02 PM, Staff B revealed that the facility sent Resident #13 to a local hospital after the resident was at the facility shaking and with for 5 days. Review of facility's record showed that there was no documentation indicating the facility continuously monitored residents for signs and/or symptoms of COVID-19. The facility documented the residents' temperature on , , ,20, , and . During an interview on at 12:10 PM, Staff B stated she did not work on Saturday or Sunday, the and 2nd. The staff added she checked the residents' temperature for the rest of missing dates, but she forgot to document them. During an interview on at 1:27 PM, the administrator stated that staff received COVID-19 training and control training. She stated that Staff G who had been sick with COVID-19 for 3 weeks, provided this "extensive training". The administrator stated that staff at the facility had plenty of supplies. During an interview on at 1:31 PM, the administrator stated having the missing	A 030		

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A 030	Continued From page 24 temperature logs and screening logs with her at her house. The administrator took them with her because the facility was disorganized. She would find out about the missing logs. On at 4:16 PM during a telephone interview, [Registered Nurse (RN)_A] stated that she took care of one resident, and that she was informed of his COVID -19 positive status on the House Manager. She further stated that when she took care of COVID-19 positive residents, she wore the following PPE: . . . shield, mask, and gloves. She also stated that she provided nursing service at Villa Serena 1, 3, 4, and 6. On at 3:45 p.m., Staff B stated that the resident census was 13, and she was the only staff at the facility that was assisting with the residents' needs. She stated that Staff C, who had been experiencing symptoms of exhaustion related to her COVID-19 positive status during the state's visit to the facility on , had become worse and could not come to work. Staff B further stated that residents did not like to wear their . . . masks. On at 3:45 p.m., two residents were observed in the hallway. Resident #1, who was positive with COVID-19, was sitting in his wheelchair and requested assistance with a bath. He was wearing a surgical . . . below his ; it was not covering his and . Pushing Resident #1's wheelchair was Resident #12, who had tested negative for COVID-19. Resident #12 was not wearing a . . . mask. Also, residents #9 and #11 were observed in the television area sitting next to each other; resident #9 was not wearing a mask, and resident #11 was wearing a surgical . . . mask.	A 030		

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A 030	Continued From page 25 Class I	A 030		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C.	A 055		

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A 055	Continued From page 26 (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f).	A 055		

Agency for Health Care Administration

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A 055	Continued From page 27 (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to keep medications locked at all times. Findings included: Observation on at 12 PM showed that Resident #8 rested on bed in # . There was tube of , Cream 0.77% labeled with Resident #8's name on the top of the nightstand. During an interview on at 12 PM, Staff B stated Resident #8 requested her to the medication to him. Staff C gave the tube of cream to the resident but Resident #8 did not return the medication to the staff. Review of Resident #8's record showed that there was health assessment completed on indicating the resident had medical history and diagnoses of , , , and , . Resident #8 who required assistance with self-administration of medication suffered of behavior changes and loss of memory.	A 055		

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A 055	Continued From page 28 Observation on . . . . . at 12:13 PM showed that Resident #15 rested on bed in # . There was a sink vanity inside . . . #. and there was a medication on the top of it. The medication was . . . Diskus . . . . . . During an interview on . . . . . at 12:13 PM, Staff B stated giving the medication to Resident #15 after he requested it to the staff. The staff forgot to pick up the medication when the resident finished using the medication. Review of Resident #15's record showed that there was health assessment completed on . . . . . indicating the resident had medical history and diagnoses of , , prostatic hyperplasia, , , , , , , , . The resident #15 required assistance with self-administration of medication. Class III	A 055		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416	A 079		

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A 079	Continued From page 29	A 079		

66-75	457
76-85	498
86-95	539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and .

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A 079	Continued From page 30 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct	A 079		

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A 079	Continued From page 31 care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing	A 079		

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A 079	Continued From page 32 home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern. Findings included: Observation on [redacted] at 11:33 AM showed that Staff B opened the facility's door while stating that Staff C also was on duty. During an interview on [redacted] at 11:33 AM, Staff B stated the facility's census was of 15 residents, but two of them were out to the hospital. The staff added that nine residents at the facility and the two staff members on duty tested positive to COVID-19. Observation during the tour completed at the facility on [redacted] from 11:47 AM to 12:13 PM showed that Residents #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, #14 and #15. During an interview on [redacted] at 12:23 PM, Staff C stated starting to work at the facility around [redacted]	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953233	A. BUILDING: _____ B. WING _____	08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA SERENA II	60-62 NW 33 AVENUE MIAMI, FL 33125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 33 Observation on . . . . . at 12:20 PM showed that there were two staff schedules posted on the bulletin board. Review of the two staff schedules covered one from to and the other one from . . . . . to . . . . . . None of the posted staff schedules included Staff C. During an interview on at 12:19 PM, Staff B stated the staff schedule was old. The facility had some issues with staffing because staff members changed. The facility's staff would change staff again on upcoming Wednesday because a new staff would start. Class III	A 079		