

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910926</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/22/2022</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**VILLA ROSA I, INC**

**182 WEST 9 STREET  
HIALEAH, FL 33010**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| CZ813<br>SS=D            | <p>59A-35.090(3)(c), FAC Results of Screening &amp; Notification in File</p> <p>59A-35.090 Background Screening.<br/>(3) Results of Screening and Notification.<br/>(c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to have the eligibility results of employee screening in the employee's personnel file for one out of six sampled staff (Administrator).</p> <p>Findings included:</p> <p>Personnel records review for the Administrator showed no documentation of a current eligibility result of background screening. The result on file showed eligibility date on _____ and _____ expiration date was on _____.</p> <p>Review of the facility's background screening clearinghouse showed the Administrator's latest eligibility date was _____.</p> <p>On _____ at 3:15 PM, the Manager acknowledged that the Administrator's current eligibility result was not on file.</p> <p>Class III</p> | CZ813               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ROSA I, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>182 WEST 9 STREET<br/>HIALEAH, FL 33010</b> |                                                                                                                          |                                                        |
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| A 000                                                        | Initial Comments<br><br>A re-licensure survey was conducted at Villa Rosa I Inc. on ..... Deficiencies were identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | A 000                                                                                   |                                                                                                                          |                                                        |
| A 081<br>SS=D                                                | 429.52(1 & 7) FS; 59A-36.011( ) FAC Training<br>- Staff In-Service<br><br>429.52(1)<br>(1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.<br><br>(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.<br><br>59A-36.011<br>(2) STAFF PRESERVICE ORIENTATION.<br>(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). | A 081                                                                                   |                                                                                                                          |                                                        |

AHCA Form 3020-0001  
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| A 081                                                        | <p>Continued From page 1</p> <p>(b) New staff must complete the preservice orientation prior to interacting with residents.</p> <p>(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.</p> <p>(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:</p> <ol style="list-style-type: none"> <li>1. Resident's rights; and,</li> <li>2. The facility's license type and services offered by the facility.</li> </ol> <p>(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:</p> <p>(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement.</p> <p>(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:</p> <ol style="list-style-type: none"> <li>1. Reporting adverse incidents.</li> <li>2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.</li> </ol> | A 081                                                                                   |                                                                                                                          |                                                        |

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| A 081                                                        | <p>Continued From page 2</p> <p>(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:</p> <ol style="list-style-type: none"> <li>1. Resident rights in an assisted living facility.</li> <li>2. Recognizing and reporting resident _____, neglect, and _____. The facility must use its _____ prevention policies and procedures when offering this training.</li> </ol> <p>(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:</p> <ol style="list-style-type: none"> <li>1. Resident behavior and needs.</li> <li>2. Providing assistance with the activities of daily living.</li> </ol> <p>(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.</p> <p>(f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.</p> <ol style="list-style-type: none"> <li>1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.</li> <li>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.</li> </ol> <p>This Statute or Rule is not met as evidenced by:</p> | A 081                                                                                   |                                                                                                                          |                                                        |

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| A 081                                                        | <p>Continued From page 3</p> <p>Based on record review and interview the facility failed to ensure that two out of six sampled staff had documentation of the required in-service training (Staff D and Staff E).</p> <p>Findings included:</p> <p>Review of personnel records for Staff D and Staff E showed no documentation of the employees having received all the pre-service training's prior to interacting with residents. There was no documentation of training on facility's policies and procedures regarding elopement for Staff D and Staff E.</p> <p>Also, there was no documentation of one hour of in-service training on reporting major incidents, reporting adverse incidents &amp; facility emergency procedures; one hour of incident reporting training; or one hour training on resident rights and recognizing and reporting resident neglect, and _____ within 30 days of employment for Staff E.</p> <p>Staff D's hire date was _____ and Staff E's hire date was _____</p> <p>On _____ at 3:15 PM, the Manager acknowledged that Staff D and Staff E had not completed all the required staff in-service training's within 30 days of employment.</p> <p>Class III</p> | A 081                                                                                   |                                                                                                                          |                                                        |
| A 084<br>SS=D                                                | <p>59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds &amp; Med Mgmt</p> <p>59A-36.011<br/>(6) ASSISTANCE WITH THE<br/>SELF-ADMINISTRATION OF MEDICATION AND<br/>MEDICATION MANAGEMENT. Unlicensed</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A 084                                                                                   |                                                                                                                          |                                                        |

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| A 084                                                        | Continued From page 4<br><br>persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria:<br><br>(a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance.<br><br>(b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to:<br><br>1. Read and understand a prescription label;<br>2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including:<br>a. Assist with oral dosage forms, _____ dosage forms, and _____, and dosage forms; | A 084                                                                                   |                                                                                                                          |                                                        |

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NAME OF PROVIDER OR SUPPLIER

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**VILLA ROSA I, INC**

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| A 084                    | Continued From page 5<br><br>b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;<br>c. Recognize the need to obtain clarification of an "as needed" prescription order;<br>d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;<br>e. Complete a medication observation record;<br>f. Retrieve and store medication;<br>g. Recognize the general signs of adverse reactions to medications and report such reactions;<br>h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;<br>i. Assist with _____;<br>j. Use a _____ to perform _____ testing;<br>k. Assist residents with _____ and continuous positive airway pressure (CPAP) devices, excluding the titration of the _____ levels;<br>l. Apply and remove _____ stockings and hosiery;<br>m. Placement and removal of _____ bags, excluding the removal of the _____ or manipulation of the _____ site; and,<br>n. Measurement of _____ rate, temperature, and _____ rate.<br>(c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have | A 084               |                                                                                                                          |                          |

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| A 084                                                        | <p>Continued From page 6</p> <p>successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online.</p> <p>(d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n.</p> <p>429.52</p> <p>(6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation, record review and interview, the facility failed to have up-to-date training on assisting with self-administration of medication for two out of six sampled staff (Staff C and Staff F).</p> <p>Findings included:</p> <p>On at 1:00 PM, observation showed</p> | A 084                                                                                   |                                                                                                                          |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910926</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/22/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ROSA I, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>182 WEST 9 STREET<br/>HIALEAH, FL 33010</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 084                                                        | Continued From page 7<br><br>Staff C (supervisor) assisted the residents with self-administration of medication.<br><br>Personnel records review for Staff C showed no documentation of a completed initial 6-hour training on assisting with self-administration of medication. Staff C completed 4-hour training on assisting with self-administration of medication on . . . . . Staff C's hire date was . . . . .<br><br>Personnel records review for Staff F (supervisor) showed no documentation of a completed initial 6-hour training on assisting with self-administration of medication. Staff F completed 4-hour training on assisting with self-administration of medication on . . . . . Staff F's hire date was . . . . .<br><br>On . . . . . at 3:14 PM, the Manager acknowledged that Staff C and Staff F had not completed the initial 6-hour training and he stated that only the supervisors assisted the residents with the medications.<br><br>Class III | A 084                                                                                   |                                                                                                                          |                                                        |
| A 162<br>SS=D                                                | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. . . . ,<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of other health insurance . . . . ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | A 162                                                                                   |                                                                                                                          |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910926</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/22/2022</b>                                                                                                   |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ROSA I, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>182 WEST 9 STREET<br/>HIALEAH, FL 33010</b> |                                                                                                                                                          |
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| A 162                                                        | <p>Continued From page 8</p> <p>8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and,</p> <p>9. Name, address, and telephone number of the health care provider and case manager, if applicable.</p> <p>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.</p> <p>(c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.</p> <p>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.</p> <p>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.</p> <p>(f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually.</p> <p>(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.</p> <p>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.</p> <p>(i) A copy of the resident's contract with the facility, including any addendums to the contract</p> | A 162                                                                                   |                                                                                                                                                          |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ROSA I, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>182 WEST 9 STREET<br/>HIALEAH, FL 33010</b> |                                                                                                                                                          |
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| A 162                                                        | <p>Continued From page 9</p> <p>as described in rule 59A-36.018, F.A.C.</p> <p>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.</p> <p>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S.</p> <p>(l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____, CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a>. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.</p> <p>(m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.</p> <p>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.</p> <p>(o) The resident's _____, DH Form 1896, if applicable.</p> <p>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services,</p> | A 162                                                                                   |                                                                                                                                                          |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ROSA I, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>182 WEST 9 STREET<br/>HIALEAH, FL 33010</b> |                                                                                                                          |
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| A 162                                                        | <p>Continued From page 10</p> <p>record keeping may be limited to the following at the discretion of the facility:</p> <ol style="list-style-type: none"> <li>1. A log listing the names of residents participating in this arrangement,</li> <li>2. The resident demographic data required in this paragraph,</li> <li>3. The health assessment described in rule 59A-36.006, F.A.C.,</li> <li>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,</li> <li>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.</li> </ol> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to maintain an up-to-date health assessment for one out of 14 sampled residents (Resident #1).</p> <p>Finding include:</p> <p>A review of Resident #1 Health Assessment (AHCA 1823) dated _____, showed that the type of assistance needed for medication was left</p> | A 162                                                                                   |                                                                                                                          |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910926</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/22/2022</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**VILLA ROSA I, INC**

**182 WEST 9 STREET  
HIALEAH, FL 33010**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 162                    | Continued From page 11<br><br>blank.<br><br>In an interview with Staff B on _____ at 12:00<br>PM, Staff B acknowledged that the type of<br>assistance needed for medication was left blank<br>on the health assessment.<br><br>Class III | A 162               |                                                                                                                          |                          |