

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/06/2022
NAME OF PROVIDER OR SUPPLIER VILLA SERENA III			STREET ADDRESS, CITY, STATE, ZIP CODE 1777 NW 30 STREET MIAMI, FL 33142		
(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 000	Initial Comments A biennial re-licensure survey, with a Limited Mental Health component, was conducted at Villa Serena III on A deficiency was identified at the time of the survey.	A 000			
A 182 SS=F	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all staff were trained in their duties and would be responsible for implementing the emergency management plan for one out of three (Staff C) sampled staff. Staff C did not know how to start the alternate power source (portable generator). Findings Included: Observation on at 7:18 AM revealed a Champion Dual Fuel portable generator inside of a shed outside of the facility. On at 9:47 AM, Staff C was asked to start the generator and did not know how to start the generator. Class III	A 182			

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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