STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966710	08/18/2015
NAME OF PROVIDER OR SUPPLIER **VILLA SERENA**	STREET ADDRESS, CITY, STATE, ZIP CODE **754-56 N W 22 CPURT** **MIAMI, FL 33125**	

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

0000 Initial Comments

A limited nursing services monitoring survey was conducted on , 2015. Villa Serena with Limited Nursing Services component had the following deficiency found at time of survey:

0030 Resident Care - Rights & Facility Procedures

Based on observation, record review, and interview, the Assisted Living Facility failed to have a consent of the resident or the resident's representative or designee or the resident ' s surrogate, guardian, or attorney in fact for the use of physical restrain for one (#1) out of two sampled residents.

Findings included:

Observation on at 9:52 AM revealed that Resident #1 was in bed with bed rail up.

Record review of Resident #1's hospice file revealed that there was a doctor order for full bed rail but there was no consent of the resident to the use of bed rail.

In an interview with the Administrator on at 10:35 AM revealed that she did not know that facility requires to have a consent for the use or bed rails.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Villa Serena
754-56 N W 22 Cpurt
Miami, FL 33125

Dear Administrator:

This letter reports the findings of a Limited Nursing Services Monitoring survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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