STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912024	10/28/2015
NAME OF PROVIDER OR SUPPLIER **VILLA SERENA I**	STREET ADDRESS, CITY, STATE, ZIP CODE **1200 SW 22 TERRACE** **MIAMI, FL 33145**	

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

0000 Initial Comments

A Complaint (CCR #2015008729 and 2015010045) Survey on conducted on / / and concluded on . Villa Serena I had deficiencies identified at the time of the survey.

0025 Resident Care - Supervision

Based on observation, interviews, and record review, the failed to document changes in condition regarding skin conditions, incontinence, and for two of fifteen residents (Residents #1 and #15).

Findings:

On / / at 8:49 am, Resident #1 stated that she sits in the same chair all day and has wounds on her back, which hurt more because of sitting all day and because of lying in all night. The resident further stated that she needs physical for her legs and hasn't had it in five months, and that her legs hurt. Resident stated that it itched. Resident also stated that at night nobody changes her adult brief and she wakes up full of .

On / at 12:15 pm, a nursing assessment (by an Agency AHCA nurse) found Resident #1 had the following: Resident had a on her areas, her and under her . On her right resident had three small wounds that were caused by the resident scratching the area.

Resident #1's discharge papers from the hospital stated right leg had redness and dry scabs; resident had a diagnosis of .

On / at 12:20 pm, the Administrator stated that the resident had been refusing to go to the hospital but allowed the caregivers to applied and another cream that the health care provider ordered.

On / / at 12:25 pm Staff A stated that Resident #1 gets up and drinks water all night. She also stated during the nursing assessment that Resident #1 wakes up in the morning full of . Staff A then stated that they try to awaken the resident to take her to the they are unable to rouse her.

On / / at 12:32 pm, the Administrator stated that if the resident needed her adult brief to be changed during the night, she would need to be moved to another level of care since the assisted living facility is inadequately staffed to provide this service.

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Record review found Resident #1's health assessment documented that she was diagnosed with and decline in function; she required assistance with toileting. Record review revealed that there is no documentation of any change of condition, nor of the wounds or the treatment in Resident #1's record.

On / / at 12:32 pm, the Administrator stated that the reason there was nothing in Resident #1's record about the change of condition or the wounds is because the doctor keeps his own files at his office.

Record review of a collaborative agency's findings revealed a finding that the facility did not adequately supervise Resident #15, which resulted in multiple with injury to the resident. A review of the facility record for Resident #15 revealed that there is no documentation that the resident ever in the facility. Documented interviews by the collaborating state agency revealed that the resident often threw herself on the floor, and injury resulted on at least one occasion. Since the were not documented, there is also no documentation of interventions done to intervene, or to find a more appropriate setting for the resident.

Class III

0052 Medication - Assistance with Self-Admin

Based on interviews and record review, the facility failed to assist thirteen of fifteen residents (Residents #1-13) with self-administration of medication as prescribed by statutory requirements 4292.256 FS. Findings:

On / / at 10:18 am, Resident #4 stated that the staff tells her that she has to go to bed at 6:00 pm. She further stated that she takes whatever medication they give her at 6:00 pm or before she goes to bed.
On / / at 10:51 am, Resident #7 stated that staff gives him the medications at around 6:00 pm.
On / / at 11:30 am, Resident #10 stated that he goes to bed at 10:30 or 11 pm. Staff gives him his medication when he comes for dinner at 4:30 or 5:00 pm, and he saves them.
On / / at 11:38 am, Resident # 11 stated that staff gives him evening medications with dinner (served between 4-6 pm) and he saves them and takes them at 10:30 or 11 pm before he goes to bed.
On / / at 1: 26 pm, The Administrator was questioned regarding Staff A giving residents their medications in their hands with dinner (at 5 or 5:30 pm), and not watching the residents swallow the medications, the Administrator stated "I have to retrain her."
Record review of the Medication Observation Records (MORs) revealed that evening medications for Residents #1-13 are scheduled to be given at 8:00 pm. Record review revealed that the MORs for

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Residents #1-13 scheduled to be given at 8:00 pm were signed, with no documentation of the medications having been given three or more hours early.
The facility staff provided 8:00 pm medications to residents between 4 and 6 pm daily, signed the Medication Observation Records (MORs) for the 8:00 pm time, and instructed residents to take the medications before going to bed.
Class III

0162 Records - Resident

Based on observation and interview, the facility failed to maintain a record on file at the facility for one of fifteen residents (Resident #14). The resident's file was kept off site at an office or other facility, and was not available on-site at the facility for review.
Findings:
On / during a complaint survey inspection, Resident #14's record was not available at the facility for review.
On / / at 10:00 am, the Administrator stated that she would obtain the resident record and fax or bring copies of it to the field office.
On / / at 6:38 pm, the Administrator communicated by email that Resident #14's file was too large to send by fax so it would be available for review at the facility.
On / Resident #14's record was still not available at the site for review.
On / at 12:59 pm, the facility's Manager acknowledged that the record was not at the facility, and stated that she would bring it to the field office.
On / , record review revealed that Medication Observation Records (MORs) for months past were not found in Resident #14' s record. When presented, the resident's file was incomplete and did not contain the name and contact information for the resident's current case manager.
On / at 8:45 am, the facility Manager acknowledged that the MORs were not in the file, and stated that she would bring them to the field office.
Class III

L241 LMH - Records

Based on interview and record review, the facility failed to obtain an appropriate placement assessment provided by the resident's licensed mental health care provider within 30 days of admission to the facility for one of fifteen residents (Resident #14). The facility also failed to ensure than a community living support plan was prepared within 30 days of Resident # 14's admission to the facility.

Findings:
On , record review revealed that a community living support plan which had been prepared

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within 30 days of Resident#14's admission to the facility on was not in the resident 's file.
On at 9:30 am, the facility's Manager acknowledged that a community living support plan which included the of the facility to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities identified in the plan that had been provided or arranged for by the resident's mental health care provider or case manager, and which included a description of other services to be provided or arranged by the facility, was not in Resident #14 's file.

The facility's Manager later stated that she would bring it to the field office, however no plan was provided.

A review of the Resident #14's Health Assessment form 1823 dated / revealed that the resident is diagnosed with
A review of Resident #14' s record revealed a community living support plan from his prior facility dated / . This plan indicated that the resident had a history of appointments every four weeks, facilitated by the case manager and the facility staff.
A review of the Resident #14's record revealed no documentation that the resident had been seen by a psychiatrist since his admission to the facility on
On at 9:25 am, a representative of the case management agency where the community living support plan dated / was completed stated that the case manager identified on the form no longer worked for the company and that Resident #14 was not known by current agency staff.
On at 1:03 pm the facility's Manager confirmed that Resident #14 receives ( ) funds.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Amended

Administrator
Villa Serena I
1200 Sw 22 Terrace
Miami, FL 33145
RE: CCR #2015008729 and 2015010045

Dear Administrator:

This letter reports the findings of a complaint survey that was completed 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

XG90

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