STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912024	R
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 Revisit conducted on 12/30/15. Villa Serena I with limited mental health and limited nursing services components had deficiencies found at the time of the survey.

0054 Medication - Records

Based on record review and interview the facility failed to maintain accurate daily medication observation records (MORs) for each resident who receives assistance with self-administration of medications for two out nine (#1 and #2) sampled residents.
Founding included:
Observation on at 12:30 PM showed Resident #1's 0.5 mg bingo card punched (which indicated that the medication was given to the resident)
Record review found the MOR was not initialed for Resident #1's . Further record review found Resident #2's 100 MG for 8:00 PM was signed as given on before the documented time on the MOR.
During an interview on at 12:45 PM Staff B (caregiver) acknowledged the findings. She stated I'm sorry, I miss the places on the MOR and I signed it today.
Class III

0057 Medication - Over The Counter (OTC) Products

Based on observation and interview the facility failed to ensure all over the counter (OTC) medications were properly labeled with the resident's name.
Findings included:
Observation on showed OTC medications C (dietary supplement) 250 mg and (chewable) 81 mg were not labeled with Resident #2's name.
During an interview on at 12:45 PM Staff B (caregiver) acknowledged the finding and she stated I did have this OTC medication in Resident #2's medication bag so this way I know is her medication.
Class III

0162 Records - Resident

Based on record review and interview the facility failed to maintain a completed record at the facility for one out of nine sampled residents (#2). The facility also failed to have a copy of the written informed consent to have unlicensed staff assisting the resident with the self-administration of medication for one

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

out of nine sampled residents (#2). The facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney (POA) for one out of nine sampled residents (#2).
Findings included:
On at 12:09 PM requested record for Resident #2, admitted on / , Staff C provided blank forms. On at 1:19 PM Staff C received a fax from the office with Resident #2's acknowledgment of admission packages dated / signed by a grandson. The agreement for care (contract) dated / was also signed by a grandson. Further record review showed that the facility did not have a POA, guardianship, or surrogate documentation for Resident #2. Record review found the facility did not have an inform consent to assist with self-administration of medications by unlicensed personnel signed by resident for review.
Reviewed the medication observation records (MORs) for Resident #2. It showed facility staff assisted Resident #2 with the following medications: C 250 mg, 81 mg, sod 40 mg one tablet every day, 20 mg one tablet every day, 10 MG one tablet every day, and 100 MG at 8:00 PM was signed as given on .
During an interview at 1:30 PM Staff C acknowledged that the record was not at the facility and the fax received was incomplete record. She stated I do not have the power of attorney on record, the only thing that facility have is a letter from her grandson.
Uncorrected Class III

AH Form Approved

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
AL11912024

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
12/30/2015

Name of Facility
VILLA SERENA I

Street Address, City, State, Zip Code
1200 SW 22 TERRACE
MIAMI, FL 33145

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **A0025** Reg. # **429.26(7) FS: 58A-5.0182(1** LSC	Correction Completed	ID Prefix **A0052** Reg. # **58A-5.0185 (3)** LSC	Correction Completed	ID Prefix **AL241** Reg. # **429.075(3-4); 58A-5.029(2)** LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** LS	**Date:** 1/13/16	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Villa Serena I
1200 Sw 22 Terrace
Miami, FL 33145

Dear Administrator:

This letter reports the findings of a complaint revisit survey conducted on , 2015by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com