| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968299 | 05/04/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**VILLA ESTRELLA ALF INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**15580 SW 146TH**<br>**MIAMI, FL 33177** | |

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

**0000 Initial Comments**

A Standard Biennial survey was conducted on . Villa Estrella ALF Inc with Limited Mental Health component had no deficiencies found at the time of the survey.

**0010 Admissions - Continued Residency**

Based on observation, record review, and interview the facility failed to ensure that residents met the continued residency criteria for one out of six sampled residents (Resident #2).

Findings included:

Observation on at 9:30 AM showed Resident #2 was sitting in the common . The resident was awake and alert.

Review of Resident #2's record on at 11:00 AM showed she was admitted to the facility on and has a diagnosis of , personal history of , polymyalgia, , chronic kidney . The health assessment documented that Resident #2 required assistance with ambulation, bathing dressing, and transferring, she also required supervision with eating, and toileting.

Interview on at 2:10 PM, the facility's Administrator confirmed that sampled Resident #2 was unable to assist with her own transfer; therefore the residents no longer met the criteria for continued residency and would be discharged from the facility.

Class III

**0030 Resident Care - Rights & Facility Procedures**

Based on observation, record review, and interview the facility failed to obtain a written physician's order for the use of a half-bed rail for 1 out of 6 (Resident #3) sampled resident.

Findings included:

Observation on at 9:20 AM showed Resident #3 had half bed rails attached to her bed.

Record review on for Resident #3 revealed the facility did not have a written physician's order for the use of half bed rails.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11968299** | **05/04/2016** |
| NAME OF PROVIDER OR SUPPLIER **VILLA ESTRELLA ALF INC** | STREET ADDRESS, CITY, STATE, ZIP CODE **15580 SW 146TH MIAMI, FL 33177** | |

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

Interview on at 2:10 PM, the facility's Administrator acknowledged the findings and she stated, "I do not have the physician's order for the half bed rail in her record."

Class III

**0079 Staffing Standards - Levels**

Based on observation, record review, and interview the facility failed to maintain the written work schedule.

Findings included:

Observation on at 09:20 AM showed Staff A, caregiver was in care of the residents and providing personal services to them.

Staffing schedule review showed Staff A was scheduled to be at the facility from 7 AM-7 AM and Staff C is scheduled to be at the facility from 9 AM-6 PM.

Interview on at 2:10 PM, the facility's Administrator stated "Staff C went home because she was not feeling well."

Class III

**0081 Training - Staff In-Service**

Based on record review and interview the facility did not ensure 1 out of 4 sampled employees (Staff D) received in-service training within 30 days of employment.

Findings included:

Staff record review showed Staff D, hired on / / , did not have documentation that she received 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents, 1 hour in-service training in Reporting major incidents, Reporting adverse incidents and Facility emergency procedures, 1 hour in-service training within 30 days of employment that covers Resident rights in an assisted living facility and Recognizing and reporting resident , neglect, and ; 3 hours of in-service training within 30 days of employment that covers Resident behavior and needs, and Providing assistance with activities of daily

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11968299** | **05/04/2016** |
| NAME OF PROVIDER OR SUPPLIER **VILLA ESTRELLA ALF INC** | STREET ADDRESS, CITY, STATE, ZIP CODE **15580 SW 146TH MIAMI, FL 33177** | |

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

living, in-service training within 30 days of employment that covers resident elopement response policies and procedures.

Interview on at 2:10 PM, the facility's Administrator stated "she received the in-services but I forget to sign the documents."

Class III

**0090 Training -**

Based on record review and interview the facility did not ensure 1 out of 4 sampled employees (Staff D) received ( ) policies and procedures training within 30 days of employment.

Findings included:

Staff record review showed Staff D, hired on / / , did not have documentation that she received1 hour in-service training within 30 days of employment that covers policies and procedures.

Interview on at 2:10 PM, the facility administrator stated "She received the in-services but I forget to sign the documents."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Villa Estrella Alf Inc
15580 Sw 146th
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a Standard Biennial licensure survey that was conducted on , 2016 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 , 2016.** 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

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

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida