STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968273	08/26/2016
NAME OF PROVIDER OR SUPPLIER **VILLA LINDA INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **670 W 72ND PL** **HIALEAH, FL 33014**	

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

0000 Initial Comments

A Standard Biennial survey was conducted on and concluded on / . Villa Linda Inc, license number 12258, had deficiencies found at the time of the survey.

0078 Staffing Standards - Staff

Based on record review and interview, the facility failed to obtain a statement from a health care provider that 1 of 4 (Staff B) sampled staff did not have any signs or symptoms of a communicable including .

Findings included:

Personnel record review conducted on at 10:10 AM found Staff B did not have documentation from a health care provider that she did not have any signs or symptoms of a communicable including . The form was not signed by a health care provider. Staff B was hired on / .

Interview conducted on / at 1:00 PM the Administrator confirmed that Staff B documentation from a health care provider that she did not have any signs or symptoms of a communicable including was missing the physician's signature.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to provide a safe and decent living environment.

Finding included:

During facility tour on / at 10:20 AM showed that there was a hole in the wall behind the toilet in the the food pantry.

Interview conducted on at 1:00 PM, Staff B, caregiver stated " The facility's Administrator is repairing the ."

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Villa Linda Inc
670 W 72nd Pl
Hialeah, FL 33014

Dear Administrator:

This letter reports the findings of a Standard Biennial licensure survey that was concluded 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