

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/05/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953233	(X3) DATE SURVEY COMPLETED R 12/22/2016
NAME OF PROVIDER OR SUPPLIER VILLA SERENA II	STREET ADDRESS, CITY, STATE, ZIP CODE 60-62 NW 33 AVENUE MIAMI, FL 33125	

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

0000 - Initial Comments

A Complaint Revisit Survey (CCR #2016008926, 2016006760, and 2016007749) was conducted on 12/19/16 and concluded on 12/22/16. Villa Serena II with Limited Nursing Services component, license number 8518, had deficiencies found at the time of the survey.

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to ensure that medicines were kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times.

Findings included:

Observation on at 4:30 PM showed that Resident #4's medication were kept in an unlocked closet in his . He shared the Resident #5.
Interview conducted on / at 5:30 PM, the administrator stated "Resident #4 is and independent Living. We do not assist him with his medications."

Class III

This is a new deficiency.

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview, the facility failed to appoint a Manager, the Administrator supervised three assisted living facilities.

Findings included:

Record review found the facility's administrator supervised three assisted living facilities. There was no documentation that the facility appointed a manager for the facility.

Clearinghouse review showed that the facility did not have a manager listed in the employee roster.

Interview conducted on at 5:30 PM, the facility administrator stated "Staff B is the facility manager. She took the Core test recently."

Record review found Staff B (hired) did not successfully pass the CORE competency exam.

Class III

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/05/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953233	(X3) DATE SURVEY COMPLETED R 12/22/2016
NAME OF PROVIDER OR SUPPLIER VILLA SERENA II	STREET ADDRESS, CITY, STATE, ZIP CODE 60-62 NW 33 AVENUE MIAMI, FL 33125	

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

This is an uncorrected deficiency.

Z809 - Proof of Financial Ability to Operate - 59A-35.062(3)(e)&(7), 408.803(7), 408.810

Based on record review and interview, the facility failed to provide documentation to show financial ability to operate.

Findings included:

Record review showed the facility did not have the income and expense records for the previous three months.

Interview conducted on [redacted] at 5:30 PM, the facility administrator stated "I submitted the facility's income and expenses to Tallahassee."

The assisted living facility licensure unit revealed on [redacted] the facility failed to show proof of financial ability to operate.

Unclassified Deficiency

This is an uncorrected deficiency.



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
Villa Serena II
60-62 Nw 33 Avenue
Miami, FL 33125

Dear Administrator:

This letter reports the findings of a Complaint revisit survey conducted on 2016 by 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 , 2017.**

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



STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11953233	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
Y1	Y2	Y3
NAME OF FACILITY VILLA SERENA II	STREET ADDRESS, CITY, STATE, ZIP CODE 60-62 NW 33 AVENUE MIAMI, FL 33125	

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0008	Correction	ID Prefix A0025	Correction	ID Prefix A0079	Correction
Reg. # 429.26(4-6) FS; 58A-5.0181(2) FAC	Completed	Reg. # 429.26(7) FS; 58A-5.0182(1) FAC	Completed	Reg. # 58A-5.019(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0093	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.020(2) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>JS</i>	DATE 11/3/17	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/12/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		