STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963890	**12/29/2016**
NAME OF PROVIDER OR SUPPLIER **VILLA ONI II**	STREET ADDRESS, CITY, STATE, ZIP CODE **5401 SW 98 COURT** **MIAMI, FL 33165**	

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

0000 - Initial Comments

An Abbreviated Biennial survey was conducted on 12-29-2016. Villa Oni II, license #8883, had deficiency identified at the time of the survey.

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview and record review, the provider failed to ensure that licensed individuals administered medications to 1 out of 5 (#5) residents.

Findings include:

Medication observation conducted on , 2016 at 11:53 AM revealed Staff D took a spoonful of pudding that was mixed with crushed medication (Lax) then fed it to resident #5.

On , 2016 at 11:53 AM the administrator acknowledged that resident #5 was unable to move her arms. The administrator stated that they have the prescription for the crushed medications.

Record review of resident #5's file revealed the resident is in hospice. Further review of the hospice file revealed the prescription for crushed medication dated , 2016.

Record review of staff D's file revealed no documentation showing that staff D is licensed to administer medication.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Villa Oni Ii
5401 Sw 98 Court
Miami, FL 33165

Dear Administrator:

This letter reports the findings of an Abbreviated 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 , 2017.** 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

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