STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912024	**08/01/2017**
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 Survey (CCR #2017005799) was conducted on . Villa Serena I (license #8022) with Limited Mental Health and Limited Nursing Services components had the following deficiencies identified at the time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview the facility failed to determined the continued appropriateness of residence in the facility for 1 of 15 sampled residents who exhibited aggressive behavior (#1).

Findings as follow:

Resident #1 was admitted to facility on and discharged on .

On at 9:40 a.m. Staff C stated Resident #1 was very aggressive since being admitted to facility.

On at 9:55 a.m. Staff D stated, "Resident #1 showed an aggressive behavior since her admission to facility, screaming and threatening residents and staff. She push Resident #1, hit Resident #3. She hit also Resident #4 and she had to leave from the facility. She hit Staff B very hard. On the second day after admitted, Resident #1 started her aggressiveness. I was very scared of her. She was very offensive. The police came to the facility several times. In one day the police came five times. On another night the police also came several times. The administrator used to come and talk to her, at that moment she talked very polite but when she left she started to behave as always. When she hit Staff C and the police came, they have to ask for an order to take her to the hospital because she was refusing to go and was very aggressive."

On at 10:15 a.m. The administrator stated, Resident #1 was admitted from a program at a Miami hospital where they see clients who does not have benefits."We tried to control her but she was very difficult since the beginning. The first time the police came she manipulated them and they did not her. I had to give staff Staff B one month off because the aggression she had from the resident. The police came several times for her. She was in facility for more or less 3 months." Before giving a resident a 45 day notice we try to stabilize the resident. We keep a resident a month for adjustment to the ALF condition. If they do not adjust we discharge the resident.

On residents revealed Resident #1's behavior was offensive and aggressive towards other residents and staff.

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The facility's progress notes revealed Resident #1's behavior was aggressive towards others.
On Resident was being verbal, very .
On Resident hit another resident grab her neck that almost strangle her and grabbed her arm,
On Resident was very aggressive and offensive and grabbed a resident from her arm.
On Resident was sent to the hospital because was very aggressive. Hit a resident and pushed a staff.
On Resident argued with another resident. After two hours resident showed an aggressive behavior.
On Resident argued with other resident because was not allowing residents to go out from the house. Resident #1 make the resident to shut up placing her hand in her mouth. The called the police.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interview the facility failed to honor residents rights to live in a safe and decent environment from from .

Findings as follow:

On at 10:30 a.m. Resident #11 stated, Resident #1 was very aggressive since her arrival to the facility. She was living here for about three months. On the same day she hit Staff C, I opened the door and she hit me twice. She also hit another resident and broke her . She is not living here anymore. The police came several times because of her. One day I was sleeping at night and I woke up because she was holding my nose I don't know if she wanted to kill me. She used to stand up at the door to let you go in and out so nobody could be at the door."

Resident #1 was admitted to facility on and discharged on .

Resident #1's progress notes revealed aggressive behavior towards other residents.
On Resident was being verbal, very .
On Resident hit another resident grab her neck that almost strangle her and grabbed her arm,
On Resident was very aggressive and offensive and grabbed a resident from her arm.
On Resident was sent to the hospital because was very aggressive. Hit a resident and

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pushed a staff.
On Resident argued with another resident. After two hours resident showed an aggressive behavior.
On Resident argued with other resident because was not allowing residents to go out from the house. Resident #1 make the resident to shut up placing her hand in her mouth. They called the police.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interview, and record review the facility failed to maintain daily medication observation records (MORs) for 1 of 15 sampled residents (#15).

Findings as follow:

On at 9:10 a.m. Resident #15 was observed in facility.

On at 12:44 p.m. Resident #15 stated the resident received assistance with self-administration of medications. He added Staff C gives him the medications and stores it. Resident #15 stated he already took the medications today.

On at 12:45 p.m. Staff C stated she assists Resident #15 with self-administration of medications.

The following medications for Resident #15 were kept in the medication cabinet:
, 81 mg take 1 tab by mouth daily am
Metroprolol 25 mg 1 tab by mouth daily am
, tab take 1 tab by mouth every day.
DOC-O lace 100 mg soft gel tab 1 cap by mouth twice daily.

MORs reviewed for , and (2017) revealed they were not signed by the facility as given.
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On at 1:02 p.m. Staff C stated that the person who brought Resident #15 from the hospital told her to supervise the medications for him. Staff stated she is doing that to avoid the resident taking the medications out of time or overdose.

Class III

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0160 - Records - Facility - 58A-5.024(1) FAC

Based on observation, interview, and record review the facility failed to have an up-to-date admission and discharge log.

Findings as follow:

On at 9:10 a.m. Resident #15 was observed in facility.

On at 12:44 p.m. Resident #15 stated the resident received assistance with self-administration of medications. He added Staff C gives him the medications and stores it. Resident #15 stated he already took the medications today.

Record review revealed Resident #15 was not listed on the admission and discharge log despite the resident living in the facility and receiving services from the facility staff.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation, record review and interview the facility failed to have a complete resident record for 1 of 15 sampled residents (#15).

Findings as follow:

On at 9:10 a.m. Resident #15 was observed in facility.

On at 12:44 p.m. Resident #15 stated the resident received assistance with self-administration of medications. He added Staff C gives him the medications and stores it. Resident #15 stated he already took the medications today.

On at 12:45 p.m. Staff C stated she assists Resident #15 with self-administration of medications.

The following medications for Resident #15 were kept in the medication cabinet:
, 81 mg take 1 tab by mouth daily am
Metroprolol 25 mg 1 tab by mouth daily am
, tab take 1 tab by mouth every day.

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DOC-O lace 100 mg soft gel tab 1 cap by mouth twice daily.

Record review revealed the facility failed to have a completed record for Resident #15 which included a demographic sheet, medical exam, contract, weight records, consent form for unlicensed staff to assisted with self-administration of medications, and other admission documents.

On at 12:56 p.m. the assistant administrator stated, "I did not know Resident #15 was assisted with medications" and told Staff C she was not supposed to assist him with the medications because he was independent and added it was the reason why the facility had no records of Resident #15.

Class III