STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912024	**06/01/2018**
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 (CCR #2018006114) Survey was conducted on and concluded on . Villa Serena I with limited mental health and limited nursing services components (license #8022) had deficiencies identified at the time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review, and interview, the facility failed to maintain a written record after an incident was reported to staff and have an updated assessment for one out of fourteen (Resident #1) sampled residents. The facility failed to notify the physician after an alleged incident and change in behavior for one out of fourteen (Resident #1) sampled residents.

Findings included:

On at 11:48 AM Resident #1 reported, "Staff B is the facility's manager and had a bad mood all the time." Resident #1 alleged, "I had an argument with her because I asked for my medication at 4:00 PM, and she refused. I needed to take my medication before meals. I called my physician and asked Staff C to talk to her but she refused. I went to the wash my hands. When I returned to my I was closing, my Staff B stabbed my hand with a fork. Then Staff B entered my threw the plates on top of the table. I picked up the food that felt and clean the floor. In addition, she said that she no one take care of her right hand scratch."

Interview conducted with Staff A, Administrator on at 11:12 AM reported "Resident #1 had been screaming and cursing the staff for the last days. I spoke with her a lot of times. Staff B called Staff F to inform what happened. Staff F conducted an investigation. I talked to Resident #1 next day. Resident #1 said that she tried to close her and Staff B stabbed her hand with a fork. I explained to her that this is not the best place for her, and I gave her a forty-five days' notice of relocation. She cried and asked me to transfer her to another of my facilities. I contacted resident's daughter. I did not contact her primary physician because the problem is her behavior. I have documentation of the investigation in my office."

Facility record review showed that there was no documentation of an investigation conducted after the incident involving Resident #1 and Staff B. After the survey the facility email the documentation to the Agency on . The facility did not have any documentation that Resident's #1 primary physician was notified regarding the change in Resident #1's behavior or allegations against the staff member.

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Review of Resident #1's health assessment dated indicated she has diagnoses of , , , , failure, , and , . The resident needed supervision with ambulation and required assistance with the rest of the activities of daily living. Resident #1 did not have an updated health assessment that documented a history of mental health illness.

The Department of Children and Families completed an investigation regarding the incident and could not substantiate the allegations.

Interview conducted on at 11:22 AM, Staff F stated that she came to the facility and Staff B told her that she had an incident with Resident #1 last night. She talked privately with Resident #1 who said that she tried to close her when Staff B stabbed her hand with a fork. "I talked with Staff B who denied that she stabbed Resident's #1 hand with a fork."

Interview conducted with Staff B on at 11:21 AM reported "Last Monday Resident #1 asked me for toilet paper and fried chicken wings for dinner. She got angry, and yelled to me. I went to her two plates in my hands, put the plates on the table and brought a fork and a spoon for her. Staff C came and asked me what happened. I explained to her that Resident #1 said that I stabbed her hand with a fork. The facility cameras did not work. I checked her hand and she did not have any scratch. I informed Staff F what happened and she came next day to talk to her.

Class III

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

Based on record review and interview, the facility failed to appoint in writing a manager for the facility.

Findings included:

Employee review revealed Staff A was the Administrator of the facility. Staff B was the house manager, who was not CORE trained, Staff C, D, and E were caretakers, and Staff F was the compliance officer. Review of the health finder database showed the Administrator supervised three assisted living facilities. Review facility's records showed the facility did not have a manager appointed in writing. The facility also did not provide a record for a manager, who was CORE trained.

Interview conducted on at 1:00 PM, Administrator stated that she did appoint a manager for the

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facility but the documentation was not received.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to file an adverse incident report with the Agency within one business day for one out of fourteen (Resident #1) sampled residents who alleged an incident between her and a staff member.

Findings included:

On . . . . . at 11:48 AM Resident #1 reported, "Staff B is the facility's manager and had a bad mood all the time." Resident #1 alleged, "I had an argument with her because I asked for my ⌄ medication at 4:00 PM, and she refused. I needed to take my ⌄ . . . . . medication before meals. I called my physician and asked Staff C to talk to her but she refused. I went to the . . . . . wash my hands. When I returned to my . . . . . I was closing, my . . . . . Staff B stabbed my hand with a fork. Then Staff B entered my . . . . . threw the plates on top of the table. I picked up the food that felt and clean the floor. In addition, she said that she no one take care of her right hand scratch."

Interview conducted with Staff A, Administrator on . . . . . at 11:12 AM reported "Resident #1 had been screaming and cursing the staff for the last days. I spoke with her a lot of times. Staff B called Staff F to inform what happened. Staff F conducted an investigation. I talked to Resident #1 next day. Resident #1 said that she tried to close her . . . . . and Staff B stabbed her hand with a fork. I explained to her that this is not the best place for her, and I gave her a forty-five days' notice of relocation. She cried and asked me to transfer her to another of my facilities. I contacted resident's daughter. I did not contact her primary physician because the problem is her behavior. I have documentation of the investigation in my office."

Facility record review showed that there was no documentation of an investigation conducted after the incident involving Resident #1 and Staff B. After the survey the facility email the documentation to the Agency on . . . . . .

Interview conducted with Staff B on . . . . . at 11:21 AM reported "Last Monday Resident #1 asked me for toilet paper and fried chicken wings for dinner. She got angry, and yelled to me. I went to her . . . . . two plates in my hands, put the plates on the table and brought a fork and a spoon for her. Staff C came and asked me what happened. I explained to her that Resident #1 said that I stabbed her

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hand with a fork. The facility cameras did not work. I checked her hand and she did not have any scratch. I informed Staff F what happened and she came next day to talk to her.

Review of facility's record showed that the facility did not file and submit an incident report to the agency within one day of the incident.

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Interview conducted with Staff A, Administrator on at 11:12 AM reported "Resident #1 had been screaming and cursing the staff for the last days. I spoke with her a lot of times. Staff B called Staff F to inform what happened. Staff F conducted an investigation. I talked to Resident #1 next day. Resident #1 said that she tried to close her and Staff B stabbed her hand with a fork. I explained to her that this is not the best place for her, and I gave her a forty-five days' notice of relocation. She cried and asked me to transfer her to another of my facilities. I contacted resident's daughter. I did not contact her primary physician because the problem is her behavior. I have documentation of the investigation in my office."

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Interview conducted with Staff A, Administrator on . . . . . at 11:12 AM reported "Resident #1 had been screaming and cursing the staff for the last days. I spoke with her a lot of times. Staff B called Staff F to inform what happened. Staff F conducted an investigation. I talked to Resident #1 next day. Resident #1 said that she tried to close her . . . . . and Staff B stabbed her hand with a fork. I explained to her that this is not the best place for her, and I gave her a forty-five days' notice of relocation. She cried and asked me to transfer her to another of my facilities. I contacted resident's daughter. I did not contact her primary physician because the problem is her behavior. I have documentation of the investigation in my office."

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