STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912024	R 07/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA SERENA I	**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) Revisit Survey was conducted on 07/16/18. Villa Serena I with limited mental health and limited nursing services components (license #8022) had the following deficiencies found at the time of the survey:

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

Based on observation and interview, the facility used full bed rails as . . . . for one out of 12 sampled residents (Resident #4).

Findings included:

On at 7:00 AM during the tour of the facility was observed full bed rail on Resident #4.

On at 8:00 AM the caregiver stated that the reason why they put the full bed rail to the resident is because they do not want the resident to . at night.

Class III

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

Based on observation and interview, the facility failed to ensure that centrally stored medications were locked at all times and ensure that medications in resident . . were secured. The facility also failed to ensure that medications for discharged residents were disposed.

Findings included:

On , 2018 at 7:05 am, observed a box inside closet with prescribed ointment medications for a resident who was no longer residing in the facility. At 7:30 am, observed prescribed Lantus glargine injection 100 units/ml for Resident 5 and Almebex Plus for Resident 8 inside unlocked boxes located inside unlocked refrigerator in the kitchen. At 8:00 am, observed a prescribed medication cabinet for all residents left open while staff helped another resident with self-administration of medications.

On , 2018 at 8:36 am, Staff G stated, "But Resident 5 no longer gets . , it has been suspended and it is in hold; I do not know to who the inside the refrigerator belongs to, I

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just give the medications in the book. Does it have the name of the resident?". At 9:10 am during the exit conference, the person in charge acknowledged all findings.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and record review, the facility failed updated the menu and offer substitutions that were of comparable value.

Findings included:

Record review found the menu prepared and signed by the registered dietitian for Monday, , , 2018 included: Assorted juices, toast, margarine, jelly, 1 scrambled egg, 1 bacon, milk and coffee.

On , , 2018 at 7:00 am, observed residents seating at dining table having 2 slices of toast, margarine, jelly, banana, dry cereal and milk for breakfast.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to maintain the facility with with supplies in one of four sampled and furniture in good working order for two of eight sampled , (#8 and #9).

Findings included:

On , , 2018 at 7:20 am, observed cabinet drawers inside not closing properly. At 7:25 am, observed cabinet drawers on the floor inside .

On , , 2018 at 7:20 am, resident at stated, "I know, it is hard to open and close the drawers, you need to learn the trick".

On , , 2018 at 9:10 am during the exit conference, the person in charge acknowledged the missing paper towel in the instructed the staff to replace it.

Class III

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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 and a 15 day full report for one out of fourteen (Resident #1) sampled residents who alleged an incident between her and a staff member.

Findings included:

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 .

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.

On at 7:40 AM the Administrator contacted the facility and explained that these deficiencies had been cited incorrectly thus she contacted Tallahassee and the regional office to put this deficiencies in dispute and she had not corrected anything because there was nothing to be corrected.

Uncorrected Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview the facility failed to provide documentation that the updated Emergency Management Plan was submitted and approved by the local agency.

Findings included:

Record review revealed the facility's Emergency Management Plan approval was dated .

On at 8:30 AM the caregiver stated that she was not aware of this and that she was going to inform this to the Administrator.

Class III