Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910415	A. BUILDING: _____ B. WING _____	09/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN VILLAGE	1350/1360 WEST 31 STREET HIALEAH, FL 33012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2020013989), a COVID-19 control, and generator survey was conducted at Sun Village Homes Inc on to . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the	A 025		

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A 025	Continued From page 1 resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision, and maintain a general awareness of the resident whereabouts for one out of twenty-seven Residents (Resident #1). Resident #1 had history of elopements from the facility with no intervention put in place to prevent reoccurrences. Resident #1 reported missing from the facility and whereabouts are unknown. Findings included: Observation on . . . . . at 11:50 AM showed Resident #1 was not at the facility, he was reported missing on . . . . . and still considered missing at the time of the survey. A review of Resident #1's health assessment dated . . . . . showed resident was admitted to the facility on . . . . . . The diagnoses and	A 025		

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A 025	Continued From page 2 medical history include, [redacted], [redacted]. Health assessment revealed resident had [redacted], cognition and was not an elopement risk. Resident was independent with ambulation and transferring, required supervision with eating, toileting, bathing, [redacted] and grooming and needed assistance with self-administration of medications. On [redacted] at 01:23 PM, the administrator stated on [redacted] at around 10:20 AM, Resident #2, reported to her that Resident #1 left the facility. She stated Resident #2 told her that Resident #1 jumped the wall located in the part of the facility. A review of Resident #1's record showed that the resident had previously eloped from the facility on [redacted]. Resident #1's progress notes revealed "that the resident eloped from the facility on [redacted] at around 05:00 AM. After looking for the resident, the facility called the police. The resident was found by the police about two hours later in a school nearby. The resident was brought [redacted] to the facility by the police." On [redacted] at 12:30 PM the Administrator stated prior to Resident #1 admission he had an extended history of elopements. She further stated that Resident #1 had never stayed too long in any facility. She explained that Resident #1's case manager told her that Resident #1 had a long history of eloping from Assisted Living Facilities (ALF's). She stated the resident did not want to live at facility. On [redacted] at 12:45 PM, The administrator stated that on [redacted] Resident #1 walked out of the facility but was found soon after staff noticed him missing. She explained the police	A 025		

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A 025	Continued From page 3 had to be call to assist with getting resident . . . to the facility. On at 01:37 PM, Staff B stated sometime in . . , ... Resident #1 left the facility. She stated that the last time she saw Resident #1 was around 04:00 to 04:30 PM after finishing her shift. She stated that she found out Resident #1 left the facility the next morning when she arrived to work. at 03:26 PM, Resident #1's medical case manager stated that Resident #1 eloped twice from the facility. She stated that the Administrator called her on . . . . . to inform her that Resident #1 eloped from the facility. She also stated that the administrator called her . . . in to let her know Resident #1 eloped shortly after being admitted to the facility. On . . . . . at 12:52 PM, The guardian caseworker stated that Resident #1 eloped twice from the facility. The caseworker stated on she received an email from the administrator informing her that Resident #1 had eloped from the facility. She further stated that the administrator told her that Resident #1 eloped from the facility in , but she could not remember the exact date. On . . . . . at 01:28 PM, the administrator stated an elopement risk assessment was put in place to prevent Resident #1 from eloping. She explained she informed her staff to observe Resident #1 whereabouts. She further explained that the staff conducted rounds at the change of each shift. A review of the facility's Elopement risks assessment for Resident #1 dated	A 025		

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A 025	Continued From page 4 noted, "The resident admitted at the facility on . The resident has a diagnosis of . The resident has a homeless record. He was lost for two years. The resident has gone through different ALF." " The resident was alert but imagined situations. The resident has desire to live in the street. " Review of Resident #1 records showed no documentation that rounds were conducted or interventions were put in place to prevent reoccurrences of elopement. Class II	A 025		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services,	A 162		

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A 162	Continued From page 5 therapeutic diets, ... , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S.	A 162		

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A 162	Continued From page 6 (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic	A 162		

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A 162	Continued From page 7 diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that a health assessment was accurate and up to date for one out of 26 sampled residents (Resident #1). Resident #1 identified as an elopement risk since the day of admission to the facility. Findings included: Review of Resident #1's health assessment dated [redacted] showed he was admitted on [redacted] and not considered an elopement risk. The resident was independent in ambulation and transferring; and needed supervision in eating, toileting, bathing, [redacted] and self-care (grooming). On [redacted] at 12:30 PM the Administrator stated prior to Resident #1 admission he had an extended history of elopements. She further stated that Resident #1 had never stayed too long in any facility. She explained that Resident #1's	A 162		

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A 162	Continued From page 8 case manager told her that Resident #1 had a long history of eloping from Assisted Living Facilities (ALF's). A review of Resident #1's record showed that the resident had previously eloped from the facility on [redacted]. Resident #1's progress notes revealed "that the resident eloped from the facility on [redacted] at around 05:00 AM. After looking for the resident, the facility called the police. The resident was found by the police about two hours later in a school nearby. The resident was brought [redacted] to the facility by the police." On [redacted] at 12:45 PM, The administrator stated that on [redacted] Resident #1 walked out of the facility but was found soon after they noticed him missing. The police was notified to help assist resident [redacted] to the facility. Review of the Resident #1 records showed no documentation of an accurate and updated health assessment identifying resident as an elopement risk. Class III	A 162		