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
	AL11965045	A. BUILDING: _____ B. WING _____	R 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER'S VILLAGE ALF INC	8035 SW 13 STREET MIAMI, FL 33144

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{A 000}	Initial Comments A second follow up to a biennial survey was conducted at Sunflower Village ALF, LLC from through . Deficiencies were found at the time of the survey.	{A 000}		
{A 031} SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by	{A 031}		

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{A 031}	Continued From page 1 the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide documentation of coordination of care with third party services to include documentation of	{A 031}		

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{A 031}	Continued From page 2 communications pertaining to the resident's condition and the response to treatment for 1 out of 6 sampled residents (Resident 3) Findings included: Observation on at 8:00 AM showed that Resident 3 was sitting in the living room with a walker and a , with a full bag. A review of Resident 3's record showed no documentation for third party services for the and , bag. Interviewed on at 10:00 AM Staff E stated that the home health nurses kept the records. Interviewed on at 10:30 AM a Home Health Aide stated that she worked for a home health agency, and she came every day from Monday through Friday to change Resident 3's , and clean his room, but she stated that she did not keep records. Interviewed on at 11:57 AM the Owner stated that documentation of communication with the home health agency would be included in the resident's record. Uncorrected Class III	{A 031}		
{A 032} SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS.	{A 032}		

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{A 032}	Continued From page 3 (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a	{A 032}		

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{A 032}	Continued From page 4 minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to observe its own elopement policies and procedures for 2 out of 6 sampled residents that were at risk for elopement (Resident 1 and Resident 8) Resident 1 who had previously eloped from the facility and went missing for several months was alone in the street without identification. Resident 8 was assessed to be at risk of elopement, but she did not have a form of identification on her person or a photo identification on her file. Findings included: Resident 1) Observation on at 7:45 AM showed that Resident 1 was on the street sidewalk alone.	{A 032}		

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{A 032}	Continued From page 5 Interviewed on at 7:47 AM when it was brought to her attention that Resident 1 was alone outside the facility Staff E became alarmed and ran outside to bring Resident 1 inside. Observation on at 8:00 AM showed that Resident 1 did not have a form of identification on his person listing the facility name, address or telephone number. Interviewed on at 8:05 AM Resident 1 stated that he did not have identification with him, and he did not remember the telephone number of the facility. A review of the Incident Reporting System's (AIRS) incident report# 623043 dated showed that Resident 1 had eloped from the facility on and was still missing. A review of the admission and discharge log revealed that Resident 1 was readmitted to the facility on (Photographic evidence obtained) A review of Resident 1's health assessment dated showed diagnoses of , mild functioning and special precautions for elopement risk (Photographic evidence obtained) A review of Resident 1's Elopement Risk Assessment form dated signed by the facility Administrator showed that a resident scoring greater than be considered at risk of elopement and Resident 1 had a score of 20. Further review showed that routine monitoring of the residents' whereabouts would be implemented (Photographic evidence obtained)	{A 032}		

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{A 032}	Continued From page 6 Resident 8) A review of Resident 8's health assessment dated showed that Resident 8 was at risk of elopement. Further review showed diagnoses of Type 2, dependent, ( ), without behavioral disturbance and major , status showed . Nursing requirements showed skilled nursing for administration. Needed assistance with self-administration of medicine (Photographic evidence obtained) A review of Resident 8's record showed that a photo ID of the Resident was not obtained (Photographic evidence obtained) Observation on at 9:45 AM showed that Resident 8 did not have a form of identification on his person listing the facility name, address and/or telephone number. Interviewed on at 9:47 AM Resident 8 stated that she had identification in her room but did not carry it with her. A review of the facility's Resident Elopement Policy and Procedure showed, "Standard: A safe environment is provided for residents who are at risk to . The risk of and elopement increases when residents are mobile and , , , especially if they suffer from or . An elopement can led to possible danger and must be taken seriously. Policy: As part of the admission assessment, all newly admitted residents' clinical status will be assessed by the facility administrator to determine their risk for using the Risk Scale form.	{A 032}		

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{A 032}	Continued From page 7 The facility Administrator is required to have a photo ID within 10 days of admission of residents who demonstrate to have or elopement issues" Interviewed on at 11:57 AM when told that Resident 1 was outside the facility without identification and Resident 8 was at risk for elopement and did not have a photo identification on file the Owner stated that the deficiencies would be corrected. Uncorrected Class II	{A 032}		
{A 034} SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device.	{A 034}		

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{A 034}	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain documentation in the resident's record of an assistive device the resident was using for 1 out of 6 sampled residents (Resident 2) Findings included: Observation on at 7:30 AM showed that Resident 2 was using an assistive device (a cane) when ambulating in his room. A review of Resident 2's record showed no documentation that the Resident used a cane. Interviewed on at 11:57 AM, the Owner stated that he would include documentation of the Resident's use of a cane inside the Resident's record. Uncorrected Class III	{A 034}		
{A 082} SS=D	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be	{A 082}		

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{A 082}	Continued From page 9 maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain documentation that 1 out of 3 sampled staff members had completed an education course on / ' (/) within 30 days of employment (Staff E) Findings included: A review of Staff E's record showed no documentation that she had completed an / education course. Interviewed on at 11:57 AM the Owner stated that he would include documentation of completion of the / education course in Staff E's record. Uncorrected Class III	{A 082}		