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 02/03/2026

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

(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 3rd revisit survey was conducted at Sunflower Village ALF, LLC from /20206. 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 the physician which may impact the resident's	{A 031}		

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{A 031}	Continued From page 1 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 record review and interview, the facility failed to provide documentation of coordination of care with third party services to include documentation of communications pertaining to the resident's condition and treatment for 1 out of	{A 031}		

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{A 031}	Continued From page 2 6 sampled residents (Resident #8). Findings included: During an interview on at 7:46am Staff E Stated that there were 6 residents at the facility and one of the residents was on and had a nurse come to administer her injections. Staff E identified Resident #8 as the Resident who takes . A review of Resident # 8 health assessment dated showed that the resident was diagnosed with type 2 and dependent. A review of Resident # 8 records showed that there was no documentation of the resident levels after . A review of Resident # 8 medication observation record (MOR) showed that there was no annotation that the resident received her on and . During an interview on at 7:55am Resident #8 said that she felt , two weeks ago and asked to go the hospital, but said that she did not go. During an interview on at 8:20am Staff E stated that Resident # 8 sugar was low and that why she was , when asked about Resident #8 , spell two weeks ago. Staff E stated that they called the doctor and were instructed to give the resident juice. A review of Resident # 8 medical records showed no documentation of the change of condition. During an interview on at 8:50am with	{A 031}		

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{A 031}	Continued From page 3 the home health nurse for Resident # 8 she stated that she stopped documenting the ␣ level in the facility records in and instead sends them to the resident's program of all-inclusive care. She also stated that she forgot to record the administration on and . When asked if the facility requested documentation from her regarding the ␣ levels or reminded her to sign the MOR she said no. During an interview on at 9:40am, the Administrator stated that he would call the residents program of all-inclusive care for the ␣ records. 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) 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	{A 032}		

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{A 032}	Continued From page 4 415.1051, 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 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	{A 032}		

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{A 032}	Continued From page 5 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 have an elopement response policies and procedure which requires at a minimum daily effort to determine that at risk resident have identification on their persons for 2 out of 6 sampled residents (Resident # 1 and #8) Finding included: Observation on at 8:05am showed that Resident # 1 and Resident # 8 were at the facility and no identifications were visualized on the resident during the survey. During an interview on at 8:05am Staff H identified Resident # 1 and Resident #8 when asked which resident were at risk of elopement. Staff H stated that they did not wear identification on them because they removed it and threw it away. When asked when did they throw it away staff H stated, "no se," [translation: "don't know"] A review of Resident # 1 health assessment dated showed that he was an elopement risk. He was diagnosed with , , and mild functioning. (photographic evidence obtained) A review of Resident # 8 health assessments dated showed that one of the assessments stated that she was an elopement risk and the other assessment dated that same	{A 032}		

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{A 032}	Continued From page 6 day showed that she was not an elopement risk. She was diagnosed with and major , . (photographic evidence obtained) During an interview on at 9:40am the Administrator stated that Resident # 1 did not wear his identification because he did not like it. The administrator also stated that he had no solution, when asked why residents were not wearing their identification. When asked if there was a daily log of identification checks, the administrator stated no. When asked about Resident # 8, the administrator stated that she was not an elopement risk. When asked about the incident regarding Resident # 1, the administrator stated that resident # 1 was missing for about a year and he was found in jail after being caught by police trespassing. When asked if he believed that having identification on him would have been favorable to the resident, the administrator nodded and agreed. The Administrator stated that he was going to sell the assisted living facility, when asked if he had a plan for ensuring that elopement risk residents have identification on them. A review of the facility elopement policy and procedure showed that at a minimum there will be a daily effort to determine that at risk residents have identifications on their persons, however there was no policy for resident who refusal to wear identification. (photographic evidence obtained) Uncorrected Class II	{A 032}		