STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964518	**07/15/2015**
NAME OF PROVIDER OR SUPPLIER **SUNSHINE MEADOWS**	STREET ADDRESS, CITY, STATE, ZIP CODE **1809 18TH STREET SARASOTA, FL 34234**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A complaint survey CCR# 2015006218 was conducted on / through / at Sunshine Meadows, an Assisted Living Facility located in Sarasota, Florida.

There were 2 allegations in this complaint both of which were substantiated with deficiencies.

0032 Resident Care - Elopement Standards

Based on resident record reviews, interview with administrative staff and observation, the Facility failed to ensure their policy and procedure related to elopements was followed, including investigation and staff intervention for 1 (Residents #3) of 2 residents who eloped.

The findings include:

1. The facility has several policies and procedures related to residents who elope. The first called for routine resident checks. This policy said residents will be observed every 2 hours by nursing staff. The staff will enter the resident's determine if the resident's needs are being met, and report to the supervisory nursing staff if there are any changes in the resident's condition.

The next policy related to residents who elope is called 'Elopement' (missing person). This policy provided a definition of person identified as a missing person. It included a statement that residents are encouraged to sign in and out when leaving the facility. Resident's with a noted change in usual behavior as far as going and coming and residents who have a change of condition might be considered as missing or eloped. The policy said when residents are considered to have eloped, when a person with , or whose power of attorney or guardian request the resident not leave the facility without a staff person, cannot be located. A person who leaves and does not come back by 9:00 p.m. will be considered to have eloped, if staff has not been informed the resident will be out overnight. The policy then goes on to state each situation will be evaluated individually.

The elopement policy stated it is the responsibility of the all personnel to report any resident attempting to leave or suspected of being missing to the nurses and the administrator as soon as practical. Under #4 on the policy is the following: "Should an employee discover that a resident is missing from the facility, he/she should notify the shift supervisor who should direct the staff to do the following.
a) Determine if the resident is out on an authorized leave or pass. If not, make a thorough search of the buildings and premises. If not located;
c) Notify the administrator and the nurse's notify the resident's representative;
e) Notify the police department

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f) Notify the doctor; provide search teams with resident identification information, photo and
h) Make an extensive search of the surrounding area."

2. A review of Resident #3's record revealed nurse's notes dated / / at 8:30 a.m. This note indicated the resident had not gone to , that day. At 12:00 p.m., the note stated the resident was not present in the building for lunch or medications. The note stated the resident was observed leaving the building at 10:30 a.m. The doctor was notified of the resident refusing to go to , . At 4:30 p.m., the nurse noted the resident was not in the building for the evening or for dinner and medications. The Administrator was informed. The 6:10 p.m. note stated the resident was still not in the building. On / , at 7:00 a.m. the nurse noted the resident was not present for the morning sugar testing. The night shift staff noted the resident was not in the building for the entire night. The Advanced Registered Nurse Practitioner (ARNP) was notified at that time. Not until this time was the elopement policy implemented for this resident. The police department was notified. At 10:00 a.m. the police were in the building and were provided with a picture of the resident, and a description of the clothing the resident was wearing. The resident returned to the facility at 1:55 p.m.

The staff did not implement their elopement policy until the resident was out of the building for almost 24 hours. Although the resident was alert and oriented, the resident was usually in the facility for dinner and . A review of the medication observation records for and revealed, prior to the elopement on , the resident had never missed any doses of .

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interview with administrative staff, the facility failed to file an adverse incident report for 1 (Resident #3) of 2 residents who had eloped from the facility.

The findings include:

1. Resident #3 eloped from the facility on / / at approximately 10:30 a.m. The police and adult protective services were not notified by the administrator until the morning of / . No adverse incident report was filed for this elopement.

Interview with the Administrator on at 10:30 a.m., revealed she did not think the elopement was an adverse incident so she did not file it.

Class

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Sunshine Meadows
1809 18th Street
Sarasota, FL 34234

RE: CCR #2015006218

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Laura Werts for
Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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