



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

_____, 2016

Administrator
Sun Village
_____, West 31 Street
Hialeah, FL 33012

Dear Administrator:

This letter reports the findings of a Monitoring licensure survey that was conducted on _____, 2016 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than _____, 2017.** 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90



**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 12/27/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910415	(X3) DATE SURVEY COMPLETED 12/13/2016
NAME OF PROVIDER OR SUPPLIER SUN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350/1360 WEST 31 STREET HIALEAH, FL 33012	

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

0000 - Initial Comments

A Monitoring Survey was conducted on 12-13-2016 at Sun Village Homes Inc. with Limited Nursing Services and Limited Mental Health components. There was a deficiency found at the time of the survey. (Lic# 6051)

0167 - Resident Contracts - 58A-5.025 FAC

Based on record review and interview the facility failed to have one of the two sampled residents' (2) contact completed.

Findings included:

Record review revealed that Resident #2's contract dated 11-1-2016 did not have a monthly rate documented. Resident #2 was admitted to the facility on 11-1-2016.

Phone interview with the Administrator on 12-13-2016 at 12:00 PM, she stated that the residents income from () was still pending and she was waiting for the actual amount he would be receiving from the agency.

Class III