STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910415	02/06/2017

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

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

0000 - Initial Comments

A Complaint (#2016013152) Survey was conducted from to . Sun Village Homes Inc. with Limited Nursing Services and Limited Mental Health components,(Lic# 6051) had the following deficiencies found at the time of survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interviews and record review, the facility failed to have daily observation by designated staff or facility administrator 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 for 1 out of 9 sampled residents (Resident #3). The facility failed to contact the residents' health care provider and other appropriate party after Resident #2 was reported missing to law enforcement.

Finding included:

During an interview on at 11:48 a.m. the Administrator stated, Resident #3 usually went to his son's house every day to visit his grand kids. "I don't know where is the house or the name of the person." She stated one day, , or , 2016 he went to the house his family house. He informed the facility staff that he was going to see his grandkids and he returned with the police . I was informed per facility owner that his family did not open the door for him and they called the police. "I was not here on that day."

Record review revealed Resident #3's health assessment dated had diagnoses of and . Resident #3 was not at elopement risk, he did needed supervision with activities of daily living (ADLs) ambulation, eating, transferring and assistance with dressing, eating, self-care, toileting. The Resident #3 needed assistance with self-administration of medication. Record review found the facility did not have documentation for Resident #3 when he was reported missing from the facility and found by law enforcement on .

Facility record review revealed that the facility did not follow Elopement Policy that showed that the facility should do:
"1-Establish a method for assessing resident for risk of wandering and eloping whenever admission and as needed; 2- Develop and implement preventive measure to make sure to stop wandering and eloping whenever possible; 3- Conduct and document at least two elopement drill a year.
The Procedures: 1-Administration will assess resident at risk for elopement and 2-Resident at risk will have identification on their person that includes their name, the facility's name, address and telephone number."

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

During an interview on at 1:17 p.m. Staff F (caregiver) stated, "in the case of Resident #3 I was here at the time he left the facility, but when the police returned with him I was gone for the day. He left the facility early 7:30 a.m., he told me that he was going to see his family, he used to go 2 or 3 time a week to his son's, some time they open the door at same time they do not open the door and he used to get very upset. On that day (I do not remember day or month) around 10:00 a.m. to 11:00 a.m. I did report to the other staff that Resident #3 did not return to the facility but I never thought that he was lost. I left home and I hear the next day that police drop Resident #3 back to the ALF."

During a phone interview on at 1:11 p.m. Resident #3's son stated, "the facility never told me that my dad was gone, found and returned to the facility by a police."

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observations, record review, and interview, the facility failed to have an up to date admission and discharge log.

Findings included:

Facility tour on at 10:30 a.m. found the Residents #6 and #9 were in their .

Record review revealed the facility did not have Residents #6 and #9 listed on the admission and discharge log.

During an interview on at 9:42 a.m. the Administrator stated, Residents #6 and #9 names were not in the admission and discharge log yet, they are new at the facility.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to file a 1 day and 15 day incident report for 1 of 9 sampled residents (Resident #3) who was returned missing to law enforcement.

Findings included:

During an interview on at 11:48 a.m. the Administrator stated, " , or , 2016 he

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SUMMARY STATEMENT OF DEFICIENCIES
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(Resident #3) went to the house his family house. He informed the facility staff that he was going to see his grandkids and he returned with the police." The Administrator confirmed the facility did not complete incident reports after Resident #3 was reported missing to law enforcement.

Record review found the facility did not have documentation for Resident #3 when he was reported missing from the facility and found by law enforcement on .

During an interview on at 1:17 p.m. Staff F (caregiver) stated, "in the case of Resident #3 I was here at the time he left the facility, but when the police returned with him I was gone for the day. He left the facility early 7:30 a.m., he told me that he was going to see his family, he used to go 2 or 3 time a week to his son's, some time they open the door at same time they do not open the door and he used to get very upset. On that day (I do not remember day or month) around 10:00 a.m. to 11:00 a.m. I did report to the other staff that Resident #3 did not return to the facility but I never thought that he was lost. I left home and I hear the next day that police drop Resident #3 back to the ALF."

Class III