STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910415	R 01/17/2018
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 Standard Biennial Survey Revisit was conducted on 12/28/17 and concluded on 01/17/18. Sun Village Homes Inc. with Limited Mental Health and Limited Nursing Services components, license #6051, had the following deficiencies found at the time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observations, record review, and interview, the facility failed to ensure that 2 of 23 sampled residents met continued residents requirements (#13 and #23). Residents #13 and #23 required total assistance with activities of daily living (ADLs).

Findings included:

Breakfast and medication pass observations on at 6:55 AM found Staff E fed Resident #13 oatmeal (resident was unable to hold the spoon) and held the resident's water bottle as she drank water (resident was unable to hold the bottle water). Further observations found Staff E placed Resident #13's medications into a small cup and placed the small cup into the resident's mouth and administered the medications.

Review of Resident #13's health assessment dated revealed the resident required total assistance with ambulation, bathing, , toileting, and transferring.

Review of Resident #23's health assessment dated revealed the resident required total assistance with bathing, , and toileting.

On at 11:35 AM interview with the Administrator acknowledged Resident #13 and #23's assessments had total care with activities of daily living. She stated she was going to speak to the doctor.

Uncorrected Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observations, record review, and interview, the facility failed to have a signed consent for the use of side rails for 1 of 23 sampled residents (Resident #23).

Findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910415	R 01/17/2018
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)

Facility tour on after 7:10 AM found half bed rails attached to Resident #23's bed. The Administrator revealed during the tour that Resident #23 was unable to remove the bed rails by himself.

Record review revealed Resident #23 had an order for half bed rails dated . . . . . . The facility did not have a signed consent for the use of bed rails for Resident #23.

Uncorrected Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review, and interview, the facility failed to have a licensed staff available to administer the medications for 1 of 23 sampled residents that required medication administration (Resident #23).

Findings included:

Breakfast and medication pass observations on at 6:55 AM found Staff E fed Resident #13 oatmeal (resident was unable to hold the spoon) and held the resident's water bottle as she drank water (resident was unable to hold the bottle water). Further observations found Staff E placed Resident #13's medications into a small cup and placed the small cup into the resident's mouth and administered the medications.

Review of Resident #13's health assessment dated revealed the resident required total assistance with ambulation, bathing, ب ب, toileting, and transferring. The assessment stated Resident #13 needed assistance with self-administration of medications.

On at 11:35 AM interview with the Administrator acknowledged Resident #13 and #23's assessments had total care with activities of daily living. She stated she was going to speak to the doctor.

Uncorrected Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to ensure that centrally stored medications for residents were locked up at all times.

Findings included:

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

On at 6:40 AM the medication storage bin, located in kitchen was left unlocked with cards from multiple residents. Also, additional bingo cards were left outside the medication storage bin unattended in the kitchen door.

On at 11:35 AM the findings were reviewed with the Administrator, who acknowledged the medications were left unlocked in the kitchen in the morning.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to ensure that staff and the public had access to the facility. The facility had a locked keyed gate.

Findings included:

Attempted to enter the facility on at 6:35 AM found a locked black gate. The gate did not have a buzzer or door bell available. The gate required key access. Agency staff yelled at the building to get someone's attention to unlock the door to the facility. Staff presented and unlocked the gate with a key.

Phone interview on at 12:11 PM with the fire inspector in reference to the facility's locked gates. He stated that he will go back to check the front gate doors. Phone call received from the fire inspector on at 12:31 PM revealed the facility is going to need to install a bell at the front gates.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observations, record review, and interview, the facility failed to have doctor's orders for 3 of 23 sampled residents that required medication administration and 2 of 23 sampled residents who self-administered medications (#1, #4, #14, #15, and #21.

Findings included:

1) Record review revealed Resident #1, #14, and #15's health assessment stated the residents required assistance with self-administration of medications.

Interview with the hospice nurse on at 6:50 AM revealed he administered medications to Resident #1 and #15.

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

Observations revealed a hospice nurse on after 10:00 AM administered medications to Resident #14.

2) Review of the MORs showed the following medications listed on the residents' record:
Resident #4 - Proaik inhaler, Self-administered
Resident #21 - .2% and , .005% - Self-administered

In an interview with the Administrator on at approximately 12:00 PM, The administrator stated they did not have doctor's order clarifying which medications a resident can take alone without assistance from the facility.

Uncorrected Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

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0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observations, record review, and interview, the facility failed to ensure that 2 of 23 sampled residents met continued residents requirements (#13 and #23). Residents #13 and #23 required total assistance with activities of daily living (ADLs).

Findings included:

Breakfast and medication pass observations on at 6:55 AM found Staff E fed Resident #13 oatmeal (resident was unable to hold the spoon) and held the resident's water bottle as she drank water (resident was unable to hold the bottle water). Further observations found Staff E placed Resident #13's medications into a small cup and placed the small cup into the resident's mouth and administered the medications.

Review of Resident #13's health assessment dated revealed the resident required total assistance with ambulation, bathing, , toileting, and transferring.

Review of Resident #23's health assessment dated revealed the resident required total assistance with bathing, , and toileting.

On at 11:35 AM interview with the Administrator acknowledged Resident #13 and #23's assessments had total care with activities of daily living. She stated she was going to speak to the doctor.

Uncorrected Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observations, record review, and interview, the facility failed to have a signed consent for the use of side rails for 1 of 23 sampled residents (Resident #23).

Findings included:

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

Facility tour on after 7:10 AM found half bed rails attached to Resident #23's bed. The Administrator revealed during the tour that Resident #23 was unable to remove the bed rails by himself.

Record review revealed Resident #23 had an order for half bed rails dated . . . . . . The facility did not have a signed consent for the use of bed rails for Resident #23.

Uncorrected Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review, and interview, the facility failed to have a licensed staff available to administer the medications for 1 of 23 sampled residents that required medication administration (Resident #23).

Findings included:

Breakfast and medication pass observations on at 6:55 AM found Staff E fed Resident #13 oatmeal (resident was unable to hold the spoon) and held the resident's water bottle as she drank water (resident was unable to hold the bottle water). Further observations found Staff E placed Resident #13's medications into a small cup and placed the small cup into the resident's mouth and administered the medications.

Review of Resident #13's health assessment dated revealed the resident required total assistance with ambulation, bathing, ب ب, toileting, and transferring. The assessment stated Resident #13 needed assistance with self-administration of medications.

On at 11:35 AM interview with the Administrator acknowledged Resident #13 and #23's assessments had total care with activities of daily living. She stated she was going to speak to the doctor.

Uncorrected Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to ensure that centrally stored medications for residents were locked up at all times.

Findings included:

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SUMMARY STATEMENT OF DEFICIENCIES
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On at 11:35 AM the findings were reviewed with the Administrator, who acknowledged the medications were left unlocked in the kitchen in the morning.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to ensure that staff and the public had access to the facility. The facility had a locked keyed gate.

Findings included:

Attempted to enter the facility on at 6:35 AM found a locked black gate. The gate did not have a buzzer or door bell available. The gate required key access. Agency staff yelled at the building to get someone's attention to unlock the door to the facility. Staff presented and unlocked the gate with a key.

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Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observations, record review, and interview, the facility failed to have doctor's orders for 3 of 23 sampled residents that required medication administration and 2 of 23 sampled residents who self-administered medications (#1, #4, #14, #15, and #21.

Findings included:

1) Record review revealed Resident #1, #14, and #15's health assessment stated the residents required assistance with self-administration of medications.

Interview with the hospice nurse on at 6:50 AM revealed he administered medications to Resident #1 and #15.

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SUMMARY STATEMENT OF DEFICIENCIES
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Observations revealed a hospice nurse on after 10:00 AM administered medications to Resident #14.

2) Review of the MORs showed the following medications listed on the residents' record:
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In an interview with the Administrator on at approximately 12:00 PM, The administrator stated they did not have doctor's order clarifying which medications a resident can take alone without assistance from the facility.

Uncorrected Class III