STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910926	**01/12/2018**
NAME OF PROVIDER OR SUPPLIER **VILLA ROSA I, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **182 WEST 9 STREET** **HIALEAH, FL 33010**	

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

0000 - Initial Comments

A Complaint Survey (CCR #2018000029) was conducted on through . Villa Rosa I, INC (AL #5849) with Limited Mental Health component had the following deficiencies identified at the time of the survey:

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

Based on observations, record review, and interview the facility failed to adequately provide care and services appropriate to meet the needs of the residents by not properly monitoring or supervising for 1 of 8 (#1) sampled residents. The facility failed to provide daily round sheets used to verify if residents' whereabouts.

Findings included:

On at 8:57 AM arrived to the facility and was greeted by Staff D who stated the census was 39.

On at 10:30 AM Staff B stated, "Resident #1 was an independent resident that would go to the store and come back right away. She always greeted me and she was a very pleasant lady. We never suspected she would leave the facility. I spoke to her daughter and she told me her mom had a history of drug and she had left from her other facilities, but she did not tell me this after the resident left. I have been communicating with the police department and I have called all the area hospitals. I do have any of this documented but I can transfer it to paper. I have all the calls and phone numbers on my phone. We do not have any residents that have been identified as an elopement risk."

On at 12:37 PM Staff E stated, "When I got there Resident #1 was leaving and around 12:00 PM we were waiting for her to return. I called the police after dark when I noticed she did not return. I called the police department right away. We do a daily head count where go , check for the residents. We have the list and we keep it in the office."

On at 12:50 PM Staff B stated, "I would have to ask the staff when the head count is completed and ask if they keep a log. I do not know where that is kept."

Owner was not able to produce a log or daily head count of the facility residents.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910926	**01/12/2018**
NAME OF PROVIDER OR SUPPLIER **VILLA ROSA I, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **182 WEST 9 STREET** **HIALEAH, FL 33010**	

SUMMARY STATEMENT OF DEFICIENCIES
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0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observation, record review and interview the facility failed to follow policies and procedures when responding to residents at risk for elopement.

Findings included:

Review of the facility's elopement policy revealed the facility will identify residents that have potential to be an elopement risk. Establish a method of assessing residents for risk of wondering and eloping at the time of admission and as needed. The admissions process to ascertain the resident's history of wandering/elopement, as well as alterations in mental status that could potentially contribute to a wandering/elopement behavior. The appropriate notification and documentation required by law and rule will be completed.

On at 9:01 AM Staff D stated, "these are all the residents that are not allowed to go out. We do not have a list of residents that are allowed to go out. We identify them by knowing who they are."

On at 10:30 AM Staff B stated, "Resident #1 was an independent resident that would go to the store and come back right away. She always greeted me and she was a very pleasant lady. We never suspected she would leave the facility. I spoke to her daughter and she told me her mom had a history of drug and she had left from her other facilities, but she did not tell me this after the resident left. I have been communicating with the police department and I have called all the area hospitals. I do have any of this documented but I can transfer it to paper. I have all the calls and phone numbers on my phone. We do not have any residents that have been identified as an elopement risk."

On at 12:30 PM the Administrator arrived to the facility. He stated, "We have elopement risk assessment completed by the doctor, but we did not complete one for Resident #1 because we were waiting for the doctor to return the form to us."

On at 12:37 PM Staff E stated, "When I got there Resident #1 was leaving and around 12:00 PM we were waiting for her to return. I called the police after dark when I noticed she did not return. I called the police department right away. We do a daily head count where go check for the residents. We have the list and we keep it in the office."

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, record review, and interview the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period.

Finding included:

On at 8:57 AM arrived to the facility was greeted by Staff D, other staff facility was Staff C (Supervisor), Staff G and Kitchen Staff H. Office Staff B was listed in schedule but was not present during time of entrance.

A review of the facility's staffing schedule showed Staff F was scheduled from 6:00 AM to 2:30 and Staff G was scheduled from 6:00 AM to 2:30 PM, Staff H was scheduled from 6:00 AM to 2:30 PM, and Staff I was scheduled from 6:00 AM to 2:30 PM, Staff D was scheduled as on call and Staff B was scheduled from 9:00 AM to 5:00 PM.

On at 9:26 AM Staff C stated "Staff I no longer works here, she quit today, she left a message and I am covering for Staff F because she has an appointment."

Class III