STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910926	**07/03/2018**
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 (CCR# 2018007238) survey was conducted on . Villa Rosa I, Inc (license #5849) had the following deficiencies identified at time of the survey.

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on record review and interview, the facility failed to have an updated sanitation inspection reports issued by the county health department.

Findings included:

On at 9:15 AM found the sanitation inspection reports issued by the county health department posted on the wall was dated and expired on .

Interview on at 11:00 AM the Administrator acknowledged the inspection was not updated.

Class III

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

Based on record review and interview, the facility failed to provide one out of six sampled residents with a 45 day notice of discharge.

Findings included:

Interview on at 12:30 PM Staff D stated, "Resident #1 left in the middle of the night. I was just coming on my shift when we noticed he was missing. We immediately called the police and the authorized staff."

Review of Resident #1's file revealed he was admitted to facility on . Both health assessments on file dated and documented Resident #1 was at risk for elopement.

The facility documented on , "Resident eloped from facility in the early morning hours. the police department was contacted & missing person's report was filed. It is suspected he jumped the fence between 5:30 AM/ 6:00 AM. All hospitals in the area were called. He was not located in any of the local hospitals. His guardian was notified also." On the facility wrote, "Resident was located by

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authorities and transported to hospital. We are not re-admitting this resident. His guardian was notified. Resident was found in good health."

Review of Resident #1's file found no documentation of a 45 Day notice given.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, the facility failed to complete an resident assessment for one of six (#1) sampled residents who was an elopement risk. The facility also failed to follow its own policy and procedures regarding residents at risk for elopement.

Findings included:

Review of Resident #1's file revealed he was admitted to facility on . . . . Both health assessments on file dated . . . . . and . . . . . documented Resident #1 was at risk for elopement.

A risk assessment was not completed for resident at risk for elopement. There is no documentation of any intervention created to minimize residents from eloping from the facility.

The facility documented on . . . , "Resident eloped from facility in the early morning hours. the police department was contacted & missing person's report was filed. It is suspected he jumped the fence between 5:30 AM/ 6:00 AM. All hospitals in the area were called. He was not located in any of the local hospitals. His guardian was notified also." On . . . . . the facility wrote, "Resident was located by authorities and transported to hospital. We are not re-admitting this resident. His guardian was notified."

Interview on . at 12:30 PM Staff D stated, "Resident #1 left in the middle of the night. I was just coming on my shift when we noticed he was missing. We immediately called the police and the authorized staff."

The facility policy stated, "Staff members will be trained and receive on going education on wandering and elopement behavior, assessments, and interventions." Review of the employee files found the most recent elopement training were completed in 2017.

On . at 3:00 PM the Administrator stated, "we will increase the round and hire another staff to work at night."

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure qualified staff have proof of a negative examination documented on an annual basis for one out of four (D) sampled staff.

Findings included:

Record review found Staff B did not have proof of a negative ( ) examination documented on an annual basis. The last statement for Staff D was dated and expired on .

Interview on at 3:00 PM the Administrator acknowledged after review of file that Staff D did not have an updated negative documentation.

Class III