Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2021000897) was conducted at Sunny Hills ALF of Homestead, Inc. on , to , . Deficiencies were identified at the time of investigation.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 1 resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff 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. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide care and services appropriate to the needs of one out of four sampled residents (Resident #2). Resident #2 felled multiple times at the facility without injuries and the facility failed to implement any precautions to prevent reoccurrences. Findings Included: Review of facility's 'Internal Incident/Accident Report' revealed a report dated and a 'Time of Incident' at 5:15 PM. The report revealed under 'Circumstances of Incident: At 5:15 PM, we	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 2 were called to resident room. [Resident # 2] was lying on her in her room. She stated that she . Resident stated that she was not in , , and we did not see any or . She was helped up and she walked to her chair. Resident was reminded about the use of the call light. She was given some rub massage. The daughter was notified'. The report also revealed that Staff C and Staff D were the staff members that responded to the incident. In an interview on at 11:30 AM, the Administrator stated, "Sometimes she says she and, she will be like for example, standing up and on top of her bed sitting down, but never actually . We do rounds every two hours and every hour on frequent fallers. We decrease the time if they more times. Staff document if they see something during rounds". In an interview on at 11 AM, Staff D stated, "I was at the nurse's station with [Staff C} that day ( ). [Resident # 2] was with her daughter and her daughter had left. I answered the phone at the nurse's station and her daughter told me that her mother had just called her and told her that she had . She was trying to pull the cabinet from the dresser, and she missed it and slipped and to the floor. We asked if she was okay, and she said she was fine. According to what I have seen, she has frequently". In an additional interview on at approximately 11 AM, Staff D further stated, "We're supposed to do rounds every 2 hours, but I do more than that. I do one round every hour or so. She receives more frequent rounds. No, we don't document rounds, we only document when something major happens".	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 3 Review of the facility records showed there was no documentation of conducting rounds. Review of Resident # 2's progress note dated showed 'Resident complained of in left side of the . Ambulance was called and transferred to [hospital] for further evaluation'. A second progress note dated showed 'Resident returned to facility with daughter from [hospital].' Review of Resident # 2's hospital records dated showed a Chief Complaint ' (patient) arrived via ambulance c/o (complaining of) left and states she tripped and white trying to get to the bed. reports she has had multiple on the last months. Further review of Resident # 2's hospital records showed a primary diagnosis of 'Recurrent '. Review of facility's 'Communication Log' dated showed Resident # 3's name and under 'Problem' showed 'Resident called daughter to say she . We went to her room, and she was sitting on chair'. Review of Resident # 2's clinical notes from a Primary Care Physician's (PCP) visit on showed a Chief Complaint: 'Patient came today as walk in visit with complaint of her left and after falling 3 days ago. Seen today as walk in visit after suffering several in the past 2 months due to loss of balance when she is not using her walker'. In an interview on at approximately 12:30 PM, Resident # 2's PCP stated, "[Resident # 2] is someone who has been declining the past couple of months. I referred her to a so can be further evaluated. I	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 4 remember that she has a couple of times and she came on complaining of left , and , because she had 3 days ago. I remember always talking to the daughter, but never to the facility. They will never call me if I remember correctly". Further review of Resident # 2's progress showed no documentation of any of the from , , and . There was also no documentation that showed the facility implemented any type of preventions after the first . There was no documentation of any frequent rounds conducted for Resident # 2. Furthermore, there was no documentation that showed the facility notified Resident # 2's health care provider regarding any of the three . Class III	A 025		
A 027 SS=G	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider.	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 5 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to arrange health care services for one of four sampled residents (Resident #1). Resident #1 had a and sustained a right-side forehead hematoma with ; about three weeks later, resident had an unexplainable injury; left displaced. Findings included: Review of Resident #1 health assessment dated showed an admission date for and diagnoses of right-side forehead hematoma with , amnesia, , and . The health assessment also showed resident was on Hospice care. Resident needed precautions and identified as an elopement risk. Resident needed assistance with ambulation, required two-person assistance with bathing, , grooming, eating and self-administration with medications. Review of Resident #1 progress note revealed on at 10:00 AM resident observed by staff sitting on the floor beside her bed with a small on the left forehead, and bump over right forehead. The staff helped resident to get up, she started ambulating by herself. The Staff tried to put compress on forehead, and resident pushed staff away. At noon, resident continued to ambulate along hallway and kept pushing staff away when they try to assist. Further review of the progress noted revealed on at 3:00 PM, the resident (Resident #1) was trying to climb from chair. On the forehead was healing well. fading well. On at 2:00 PM, the resident sitting in a	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 6 Geri-chair located on the memory unit in the dining room. At 5:00 PM, as resident was being transferred from chair to bed, she displayed discomfort to her left , . The Hospice nurse called the doctor and family, resident was put on continuous care and an , was taken. On at 9:30 AM, the , revealed resident had a and was transferred to the hospital, family and doctor contacted. On the family member called to advise of surgery. On the resident was transferred to a rehabilitation center. On at 10:50 AM, the Administrator stated, "on Resident #1 and sustained a small on her left forehead and a bump over her right forehead. She stated the resident's daughter did not want her to go to the hospital or urgent care. The administrator stated, "I told the daughter resident can remain at the facility and receive medical care, but only if she put her on hospice care. The daughter said yes and the next day she signed the paperwork to put her mother on hospice care. A couple of months later, the hospice staff were taking care of her and when they took her to her room and transferred her to the bed, they said, she demonstrated signs of discomfort to her . The Hospice doctor gave an order for resident to have an , done and that is when I found out she had a , . I spoke to her doctor, and it was said due to her , , her bones could break easily." Review of Resident #1 record found no diagnosis of , . On at 1:15 PM, Staff B stated, "I have been working for almost 14 years. My job is a nurse assistant. I bathe residents, assist them	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 7 with toilet needs, do laundry services and make their beds. I work form 6:00 AM to 3:00 PM. Resident #1 was very active and walked in the halls with bed sheets around her. She more than one time, before she was on hospice care. It was normal for her to walk fast. The day she , , everything changed. On the staff from hospice was in her bedroom and asked me to help her bath the resident. We gave her a bath in the shower and afterwards seated her in chair and I took her to the dining area, and she had lunch. When I left work about 3:00 PM, she was ok. The administrator called me around 4:30 PM and asked me if resident had a problem because she was complaining of , to the . I explained when I gave her a bath, she was ok. We immediately do a report when something happens. She went to the hospital, I would ask for her, she never returned to the facility." On , , at 10:30 AM during a telephone interview with Resident #1's family member, she stated, " When the staff called me on , they told me she off the bed. The staff said she had a small . The following day I was asked by the staff if they could take her to the hospital, I told them no. They suggested to me to sign my mother on hospice services, because a hospice nurse and doctor can take care of her at the facility. I agreed, and they asked me if I wanted to go to the facility to see her and sign the hospice paperwork and I did. When I went to see her, she was in a wheelchair. This is the first time I saw her and looked like if she was involved in a fight; one black . Before she was admitted to the facility, she would talk, when I saw her, she told us, "They knocked me up, but she had . I thought after I put her on hospice care she would be monitored closely. But the hospice person is not just for her. Sometime in	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 8 , , the hospice nurse called me and told me when they were putting my mother to bed at night, my mom was complaining of left , , and the doctor ordered an . The staff called me the next morning and told me she had a of her , . I went to the facility to see her; rescue was called and took her to the hospital. She had surgery, stayed in the hospital a few days, and then transferred to a rehabilitation center. She never walked again; she went downhill. She was on hospice care in the hospital, and she one day after. On at 5:37 PM, during a telephone interview with the hospice nurse assistant, she stated, "I don't work for the company anymore. I do not recall well about this resident (Resident #1). I just remember she use to walk a lot. We worked in pairs, and sometime in , we went to her room to either bathe her or put her to bed. She was complaining of , , and we call our nurse right away because it was not normal, you could tell something was wrong. After that, they took her to the hospital, and I did not see her again." Review of the hospital record revealed Resident #1 was admitted to the hospital on . "Chief Complaint" to Ed from ALF. family states . rolled out of bed 2 weeks ago the hospital record showed the patient presented to the emergency room on with complaints of left , , . The patient had a recent at the facility. The facility performed an , , and it was reported that it showed on angulated of the , left . In the emergency room, a left , , was performed and revealed acute left displaced . At that time patient was admitted and orthopedics were	A 027		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965897	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILLS OF HOMESTEAD	25268 SW 134th Avenue PRINCETON, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 9 consulted. Patient is . . . . . , she has no complaints, but she was complaining of , in the nursing home, . , showed acute left displaced . . Review of Resident #1 record found no documentation resident received medical care or any treatment from a health provider to her right-side forehead hematoma with . . . . ., after the on . On review of the record found Resident to have an unexplainable injury; a left displaced. Class II	A 027		