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
	AL11910804	A. BUILDING: _____ B. WING _____	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CHRISTIAN HOMES, INC.	5250 WHIPPOORWILL DRIVE HOLIDAY, FL 34690

(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 2026007829) was conducted at Sunshine Christian Homes on . Deficiencies were identified at the time of the survey. A Class I deficiency was found at tag A0078. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. Sunshine Christian Homes failed to initiate , , ( ) on a resident with a full code status which placed 48 residents with full code status at risk of immediate danger or harm. The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 4:15 p.m. The census at the start of the survey was 92. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 078 SS=J	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of	A 078		

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A 078	Continued From page 1 communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule	A 078		

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A 078	Continued From page 2 chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff trained in , ( ) exercised their responsibilities and duties by initiating on one (Resident #1) of one sampled resident that was found unresponsive. The facility's inaction and lack of follow up response to the event placed the remaining 48 residents with a full code status at imminent risk of harm or . Findings included: A review of the facility's self-reported incident dated revealed "[Resident #1 name] was last observed between approximately 1:30 a.m. and	A 078		

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A 078	Continued From page 3 2:00 a.m. resting in a recliner in her room without noted concerns. At approximately 6:05 a.m. to 6:24 a.m. on , during routine morning rounds, staff entered [Resident #1's name] room and observed [Resident #1] lying on the floor between the bed and bathroom area on her side and unresponsive. Upon assessment, Resident #1 was found to be unresponsive, not breathing, and without a detectable , . [Resident #1 name] did not have a ( ) order on file. was not initiated by facility staff due to [Resident #1 name] presenting without , or , and exhibiting signs consistent with already having occurred. During an interview on at 9:28 a.m. Staff E (unlicensed Medication Technician) stated she was clocking in to the 6:00 a.m. to 2:30 p.m. shift when the incident for Resident #1 occurred. Staff E stated she went into Resident #1's room and observed that Resident #1 was "half-warm and half- " and was stiff to the touch. Staff E also stated Resident #1 was not breathing and did not have a , . Staff E stated Resident #1 was a full code. During an interview on at 9:41 a.m. the Memory Care Resident Care Director stated the staff called her on the phone to inform her of the incident with Resident #1. The Memory Care Resident Care Director stated she came in around 6:30 a.m. and the local police department were at the facility. The Memory Care Resident Care Director stated Resident #1 was lukewarm, had no , and was not breathing. The Memory Care Resident Care Director was not sure if anyone initiated and stated Resident #1 was a full	A 078		

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A 078	Continued From page 4 code. During a phone interview on at 10:55 a.m. Staff A (unlicensed resident care aid) revealed she checked on Resident #1 at approximately 12:00 a.m. to 1:00 a.m. on . She said the next time she saw Resident #1 was during morning rounds at approximately 6:10 a.m. and Resident #1 was on the floor and , when she called her name, which she felt was unusual. Staff A said she called Staff B for help who checked for a , and said to contact Staff C (unlicensed Medication Technician). Staff A reported Resident #1 was not breathing, and she checked her for a , and there was no , . Staff A said Resident #1 was not stiff and the staff had moved her to an area on the floor so Staff C could provide , , ( ). She said she thought Staff C was going to do but "was told not to" by an unknown staff member and was never performed. Additionally, Staff A said she had never worked in the field and had minimal experience, so when she saw Resident #1 unresponsive she asked Staff B and Staff C what the protocol was .Staff A said Staff B and Staff C checked the chart for a and called the emergency medical services number. Staff A said she decided to leave employment at the facility approximately and there had been no retraining conducted before that. A record review of a handwritten statement by Staff A revealed that Staff A last saw Resident #1 around 1:30 a.m. to 2:00 a.m. on and she was in her recliner sleeping. Staff A's next check was not until 6:00 a.m. when she opened	A 078		

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A 078	Continued From page 5 the door and saw Resident #1 on the floor. She noted Resident #1 did not respond to her calling out to her. A record review of an incident report form written by Staff C (unlicensed Medication Technician) for Resident #1 dated at 8:00 a.m. for an incident at 6:24 a.m. The incident report revealed upon doing rounds staff went into the resident room to wake her up for breakfast, resident was on the floor next to the bed on her side and was unresponsive and had no , . Emergency medical services were called, and the Memory Care Resident Care Director was notified on at 6:30 a.m. A record review of the employee file for Staff C (unlicensed Medication Technician) revealed a termination date of . In a record review of an undated handwritten statement the Memory Care Resident Director wrote a staff member called her to tell her that a resident had , , . She said she told them to call the non-emergency number to report it. She then called the Community Director who said to call 911 instead. The Memory Care Resident Director then re-directed the staff to call 911. During an interview on at 10:38 a.m. Staff B (unlicensed resident care aid) reported coming on shift on at approximately 6:05 a.m. She walked into Resident #1's room and Staff A said Resident #1 had , Staff A wanted assistance to help Resident #1 into bed, but Staff B said they needed to turn on the light and insure there were no injuries. Staff B said she	A 078		

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A 078	Continued From page 6 turned on the light and Resident #1 was "yellowish", so she called the Memory Care Resident Care Director who said to call the non-emergency law enforcement number. Additionally, Staff B said Resident #1 had no and was warm, but no one started . Staff B said they could not assess for , so they called law enforcement to declare the resident . A record review of a handwritten statement by Staff B, dated revealed at approximately 6:05 a.m. Staff B noted she went into Resident #1's room, and she was laying on the floor. Staff B turned on the light and observed Resident #1 was not breathing and touched her . She was still warm to the touch. Staff contacted the Memory Care Resident Director and Staff C contacted the law enforcement non-emergency number to pronounce the resident . Law enforcement deputies arrived and stayed with Resident #1 until the coroner arrived to transport Resident #1 from the facility. A record review of the Resident Health Assessment Form 1823 (1823) for Resident #1 dated revealed diagnoses of toxic and . A physician evaluation note dated listed "multiple " which included and . During an interview on at 12:00 p.m. the Community Director said no in-service training had been completed for the staff and policies were being updated but were not completed.	A 078		

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A 078	Continued From page 7 During an interview on at 1:41 p.m. the Community Director said the facility's policy was if staff observed an unresponsive resident to immediately call emergency medical services, grab the automated external defibrillator ( ), perform , and use the . The Community Director said she expected staff to round on the residents every two hours. She said the Memory Care Resident Care Director told staff on to call the non-emergency medical services number for Resident #1, but she told the Memory Care Resident Care Director to have staff call the emergency medical services number instead. The Community Director said staff could have checked on Resident #1 more often and could have been present and more on top of things in the emergency for Resident #1. Additionally, the Community Director said staff now are to check on the residents hourly, but no training was conducted. During an interview on at 2:25 p.m. the Administrator said staff should check on residents every two hours throughout the night. She said she heard the staff walked into Resident #1's room on and found Resident #1 on the floor and she appeared to have , , . Staff called the Memory Care Resident Care Director who came in and said Resident #1 looked as well. She said Resident #1 did not have a ( ) order and staff called paramedics. Additionally, the Administrator said staff did not do and there were no nurses employed at the facility. The Administrator said staff did not perform proper two-hour resident checks and should have administered on Resident #1. The Administrator said no retraining	A 078		

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A 078	Continued From page 8 had been conducted for staff, and policies, procedures and corrective actions were in process. A record review of the Resident Care Aid Job Description revealed the following: Make rounds as designated by your supervisor. (Every 2 hours checks). Collaborate with healthcare professionals, including nurses and doctors, to ensure that residents receive the best possible care. A record review of the un-dated Administrator's Job Description revealed the following: Take an active role in development, implementation and administration of all job descriptions, policies and procedures pertaining to "[Facility Name]". Oversee employees of the facility in accordance with State and Federal guidelines pertaining to Assisted Living Facilities under the direction and authorization of the Board of Directors. A record review of the un-dated Resident Care Director Job Description revealed the following: Supervise and support nursing and caregiving staff, ensuring compliance with state regulations and facility policies. Review and complete incident reports, follow up on outcomes, and implement corrective action plans when needed. Provide education to staff, residents, and families on health-related topics and policies. Conduct regular care conferences and audits to ensure quality and compliance. Assist with control, safety procedures and emergency preparedness plans.	A 078		

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A 078	Continued From page 9 A record review of the facility's undated policy entitled " and Procedures" revealed the following: "Policy: [Facility Name] is committed to providing prompt emergency response measures for residents, visitors, and staff experiencing or , , emergencies. Staff will respond appropriately to medical emergencies by initiating emergency procedures, contacting emergency medical services ( ), and utilizing , , ( ) and the Automated External Defibrillator ( ) when indicated and permitted by resident directives and physician orders. 1. Emergency Response: In the event of a medical emergency involving unresponsiveness, absence of breathing, or suspected : Assess the scene to ensure it is safe for staff and residents. Check the resident for responsiveness and breathing. Immediately call for help and direct another staff member to: Call emergency medical services, retrieve the , notify the Resident Care Director and Administrator. If the resident does not have a valid on file, begin immediately according to current American Association guidelines. Continue until: emergency medical services arrives and assumes care, the resident regains responsiveness, staff are physically unable to continue, a valid [ ] is confirmed. 3. Use: " [Facility name initials] maintains an Automated External Defibrillator ( ) in a	A 078		

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A 078	Continued From page 10 designated and accessible location within the facility. " The should be used as soon as possible during suspected unless a valid is present. " Staff trained in use should follow the device prompts exactly as instructed. 4. Staff Training Requirements: Designated staff members will maintain current certification in , use, and Basic First Aid. Copies of certifications will be maintained in employee personnel files. 7. Staff Responsibilities: Care Staff will initiate emergency response procedures and when appropriate. Resident Care Director will ensure staff certifications remain current. Administrator will ensure compliance with [state agency] emergency preparedness and safety requirements." A record review of the facility's undated policy titled "Apparent of a Resident" revealed the following: "Policy: In the event of the apparent of a resident, [Facility Name] will act with respect, professionalism, and adherence to state and federal regulations. The facility will ensure that the resident is treated with dignity and that all required notifications, documentation, and procedures are completed promptly and in accordance with applicable laws. Procedure: 1. Determination of When a resident is found unresponsive, staff will immediately initiate emergency procedures and contact 911 to request medical evaluation and	A 078		

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A 078	Continued From page 11 emergency personnel. Only licensed medical personnel or authorized emergency responders may pronounce . [Facility Name] staff are not permitted to make this determination independently. Upon confirmation or pronouncement of , the following notifications must be made: 2. Notifications * Upon confirmation or pronouncement of , the following notifications must be made: Administrator or Designee - immediately Resident Care Director - for documentation and record updates. Family or Responsible Party - as soon as possible, with compassion and discretion. Resident's Physician or Hospice Provider - notified promptly to ensure proper reporting and medical record closure. Law Enforcement or Medical Examiner - when required by state law or in cases of unexpected, unattended, or suspicious . 3. Handling of the : The body will not be disturbed or moved (except to provide privacy and dignity) until pronouncement of has been made by the appropriate authority. Once pronouncement is completed, the funeral home designated by the resident or family will be contacted for transport." Photographic evidence obtained. Class I	A 078		
A 083 SS=G	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has	A 083		

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A 083	Continued From page 12 completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was an employee with first aid and , , ( ) training on duty for four employees (Staff I, J, K and L) of six sampled employees. The lack of certified staff on duty placed all residents at risk of potential harm. Findings included: A review of the staffing schedule conducted on revealed that on and during the 10:00 p.m. to the 6:30 a.m. shift, Staff I and Staff L were scheduled. On during the 10:00 p.m. to 6:30 a.m. shift, Staff I, Staff J and Staff L were scheduled. A	A 083		

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A 083	Continued From page 13 review of the direct care staff schedule for , , and , revealed Staff I, Staff J, Staff K, and Staff L were scheduled to work the 10:00 p.m. to 6:30 a.m. shift. An employee record review for Staff I, Staff J, Staff K, and Staff L, conducted on , revealed that there was no first aid and trainings documented in the employees' records. Staff I was hired on . Staff J was hired on . Staff K was hired on . Staff L was hired on . During an interview on at 4:08 p.m., the Community Director agreed Staff I, Staff J, Staff K, and Staff L did not have and First Aid training. The Community Director also agreed Staff I, Staff J, Staff K, and Staff L were on the schedule, and she would need to update the schedule with staff that had a valid and First Aid certification. (Photographic evidence obtained) Class II	A 083		