STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965897	03/04/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunny Hills Of Homestead	25268 Sw 134th Avenue Princeton, FL 33032	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced standard biennial survey was conducted on - . Sunny Hills Of Homestead had deficiencies at the time of the survey.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation and interview the Assisted Living Facility's staff failed to observe the resident to take the medication for 1 out 16 sampled resident (#7) as well as to follow appropriate procedures when assisted resident (#2, #7 and #14) with self-administration of medications.

Findings include:

Observation on during medicine review for resident #14 at 7:08 a.m. with Licensed Practical Nurse (LPN)_A revealed that LPN_A did not washed her hands or used hand sanitizer after being in contact with resident #14.

Observation on during medicine review for resident #7 at 7:19 a.m. with LPN_A revealed that LPN_A did not washed her hands or used hand sanitizer before or after being in contact with resident #7.

On at 7:22 a.m. resident #7 asked LPN_A if she could take her medicines with her to her , and LPN_A answered: "Yes", resident #7 walked away to her at 7:23 a.m. LPN_A initialed the MOR as resident #16 took her medicines. LPN_A did not observe resident #7 to take her medicines.

Observation on during medicine review for resident #2 at 7:30 a.m. with LPN_A revealed that LPN_A did not washed her hands or used hand sanitizer before getting in contact with resident #2.

In an interview with LPN_A on at approximately 7:50 a.m. she acknowledged that she should wash her hand or used hand sanitizer before and after being in contact with a resident and document in the medication observation record after observing that resident #7 took her medications.

In an interview with administrator acknowledged the findings during interview on at approximately at 9 a.m.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965897	**03/04/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunny Hills Of Homestead	**25268 Sw 134th Avenue Princeton, FL 33032**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

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

Based on observation and interview the Assisted Living Facility's staff failed to keep medications in a secured area all the times.

Findings include:

Observation on at approximately 7:10 a.m. licensed practical nurse (LPN)_A left on the hallway cap handihaler and Aer 160-4.5 inhaler on the top of the medication cart unattended.

In an interview with LPN_A on at approximately 7:50 a.m. she acknowledged that she should have medications attended by her all the times.

In an interview with administrator acknowledged the findings during interview on at approximately at 9 a.m.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Sunny Hills Of Homestead
25268 Sw 134th Avenue
Princeton, FL 33032

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after 4/23/2014 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121