STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965897	03/19/2015
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 - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments

A Complaint (CCR# 2015001822) Investigation survey was conducted on , 2015 and concluded on , 2015. Sunny Hills Of Homestead had the following deficiencies found at time of the survey:

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on record review and interview, the Assisted Living Facility failed to follow doctor ' s order for eight (#1, #2, #3, #4, #5, #6, #7, and #8) out of nine sampled residents. The facility failed to ensure that one out of nine (#9) sampled residents were not given an improper dosage amount of .

Findings included:

1. On , the facility completed an adverse incident report which stated Resident (#8) is under the care of hospice. The medication 10 mg (milligrams) by mouth every 12 hours was ordered on and faxed to the pharmacy. The order was changed to 10 mg by mouth at bedtime by the primary health care provider after the initial order was faxed to the pharmacy. The medication was written on the medication observation record as 10 mg by mouth at bedtime. The pharmacy staff was asked by staff at the facility to immediately STAT medication to the facility. The medication arrived at the facility with the label reading 100 mg by mouth every 12 hours. The medication was administered on at bedtime and on . On the medication assistant asked the licensed practical nurse (LPN) on duty to clarify the order. The LPN checked the order against the doctor ' s orders and found a discrepancy between the card and the written medication observation record. The LPN reported this to the Administrator at 10:15 am on . The LPN stayed with the resident and reported to the Administrator all vital signs were within limits. The primary care physician was notified and requested the resident to be sent to the emergency evaluation. The resident ' s responsible party was notified.

Resident #8 ' s most current health assessment (AHCA Form 1823) completed on revealed, that Resident #8 needed assistance with self-administration of medications, was under hospice services, and had diagnoses of , , and throat . Hospice record review revealed that Resident #8 was diagnosed with of the head, face, and neck.

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Record review found a copy of the doctor ' s medication prescription which revealed Resident #8 had an order for 10 mg by mouth every 12 hours dated and signed on by the hospice doctor. The doctor then discontinued the order of 10 mg every 12 hours. The doctor requested that Resident #8 start 10 mg at bed time on . The medication observation records for the month of 2014 were reviewed and revealed that Resident #8 had an order of 10 mg by mouth every 12 hours, and then it was changed to 10 mg by mouth at bedtime. It was scheduled at 9 PM and it was initialed as given on and .

Caregiver_A was interviewed on at 2:09 PM via telephone and revealed that she assisted Resident #8 with the on and she did not check the medicine label with the medication observation record until the following day when she reported to the nurse.

Caregiver_B was interviewed on at 3 PM via telephone and revealed that she assisted Resident #8 with the on , but the problem was that the medicine did not arrive that day until almost 11 PM. Caregiver_B reported, the resident went almost five times to the nurse ' s station asking for the pain medicine and as soon as the medicine ( ) arrived, she opened the package and gave the medicine to the resident. She did not check the medicine label with the medication observation record.

On at 12:20 PM, the hospice ' s team manager who was also a registered nurse was interviewed and revealed that side effects of an overdose of can be a low rate, change in level of , and a decrease in vital signs.

On at 12:25 PM, the hospice registered nurse_A was interviewed and revealed that when there was an overdose of residents can have serious problems.

The hospice doctor was contacted via telephone on at 12:04 PM and revealed that she was informed about the incident that happened with Resident #8. The hospice doctor discussed possible complications of or any other can be over sedation causing system and as a result, the patient may have serious problems.

Review of the medication observation records for Residents #1, #2, #3, #4, #5, #6, and #7 revealed medicines scheduled in the morning were not initialed by the facility staff on .

2. Resident #1 had scheduled (to treat erosive and other conditions involving excess stomach) tab 40 mg at 8:00 AM and (relaxes and improves flow) tab 2.5 mg at 8 AM and they were not initialed on the medication observation record ( ).

3. Resident #2 had scheduled at 8 AM: Sol ( ) 10 mg/15 - 15 ml; Pot Tab

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100 mg (to treat high and reduce the risk of in certain people with); (to treat erosive and other conditions involving excess stomach) tab 40 mg, (to treat or prevent , and caused by motion ...ness) tab 25 mg, Tar (to treat high pain, ...nal rhythms of the , and some neurologic conditions) tab 25 mg, and (to treat) tab 0.5 mg and ... were not initialed on the medication observation record (MOR).

4. Resident #3 had scheduled at 8 AM (to treat) tab 1 mg; (to treat and) tab 0.5 mg; (to treat) 250 mg DR and they were not ...ialed on the medication observation record (MOR).

5. Resident #4 had scheduled at 8 AM (to treat symptoms of) tab 10 m (to treat , and) tab 10 mg; (... treat) tab 10 mg, (to treat for pain relief and reduce) tab 325 mg; (to treat and prevent in the stomach and intestines) tab 20 mg and they were not ...ialed on the medication observation record (MOR).

6. Resident #5 had scheduled at 8 AM (to treat active) sus 1 gm/ 10 ml- 10 ml: Sol ( ) 10 mg/15 - 30 ml; (to treat iron deficiency) 325 (65) mg tab; (to treat) tab 10 mg; (to treat) tab 25 mg: and ... treat , tab 0.5 mg. At 6:30 AM scheduled (to treat erosive and other conditions involving excess stomach) tab 40 mg and they were not initialed on the medication observation record (MOR). Resident #5 had a pill on day #1 for tab 25 mg and a pill on day #2 for tab 40 mg.

The medication observation record for 2015 was requested for Resident #5. The Administrator returned on at 12:10 PM with a medication observation record that just had one medicine, 0.5 mg (take one tablet by mouth three times a day daily) and it was initialed by Caregiver_ ...egiver_B. The Administrator revealed that the MOR was between other papers. The Administrator returned on at 12:15 PM with two extra medication ... on records for Resident #5. Those sheets included all medicines that Resident #5 took during 2015 and they included again 0.5 mg take one tablet by mouth three times daily and it was initialed again by Caregiver_D and Caregiver_B. The Administrator revealed, that the medication observation record that she brought the first time was the wrong one and while she tried to destroy it.

In an interview with Caregiver_D on at 12:45 PM, it was reported "I signed MOR (medication observation record) twice because medication was written twice on the MOR by mistake".

In an interview with the Administrator on at 12:50 PM, it was reported "we took it out, we are correcting MORs. We did not give the medicines twice."

7. Resident #6 had scheduled at 8 AM (to treat ar... 5 mg; (to treatment of) tab 30 mg; Doxycycline (to treat

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) 100 mg cap; (to treat and prevent in the stomach and intestines) tab 20 mg; (to treat low level of) 10 MEQ yellow tab: (to treat and to improve survival after a) tab 2.5 mg; (to treat and) tab 10 mg and they were not initialed on the medication observation record (MOR).

8. Resident #7 had scheduled at 6:30 AM (to treat low activity) tab 88 mcg, (to treat and other conditions caused by excess stomach) cap 20 mg. while at 8 AM (to treat) tab 20 mg, ( ) 100 mg capsule and they were not initialed on the medication observation record (MOR).

Caregiver_C reported during an interview on at 10:36 AM, "I thought that I signed them but I forgot." Caregiver C revealed that she did not think that Resident #1 or Resident #2 knew when a medication was required and understood the purpose for taking the medication. Resident #4 was more oriented. Residents #5 and #6 were alert.

In an interview with the Administrator on at 10:55 AM revealed the consequence of not completing observation records could be that the residents received a duplicate dose. The residents received their medications every day and they knew 9 am medicines today were already given. It was an error.

Class II

0160-Records - Facility 58A-5.024(1) FAC

Based on record review and interview, the Assisted Living Facility failed to have an up-to-date admission and discharge log for one (#8) out of nine sampled residents.

Findings included:

1. Record review of the admission and discharged log revealed Resident #8 was discharged on / to the hospital.

Review of Resident #8's nursing notes revealed that Resident #8 was in the facility on and around 4 PM Resident #8 was transferred to the hospital via rescue. On Resi daughter called the facility and informed them that since Resident #8 could not receive ( ) liquids in the facility Resident #8 would stayed at the daughter's home.

2. Interview with the Administrator on at 2:56 PM revealed that probably the secretary put the wrong date.

Class III

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0162-Records - Resident 58A-5.024(3) FAC

Based on record review and interview, the Assisted Living Facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for one (#8) out of nine sampled residents.

Findings included:

1. Review of Resident #8's file revealed that the informed consent to assistance with medication by unlicensed personnel signed and dated on by Resident #8's daughter.

Interview with the Administrator on at 1:30 PM revealed that facility did not have any documentation that authorized Residents #8's daughter to sign and/or make decision for Resident #8.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR #2015001822

Dear Administrator:

This letter reports the findings of a Complaint Investigation survey that was conducted on 03, 2015 and concluded on , 2015 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.

Staff from this office will conduct a review after 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
XG90

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

ELIZABETH DUDEK
SECRETARY

, 2015

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

Dear Administrator:

This letter reports the findings of a Complaint (2015001822) Investigation survey conducted on , 2015 and concluded on , 2015, by representatives of the Agency for Health [illegible]dministration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **ten days** of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0056 - 58a-5.0185(7) Fac - Medication Labeling and Orders -Class II
Your Assisted Living Facility failed to follow doctor orders.

St - A - 0160 - 58a-5.024(1) Fac - Facility Records- Class III
Your Assisted Living Facility failed to have an up-to-date admission and discharge log.

St - A - 0162 - 58a-5.024(3) Fac - Resident Records- Class III
Your Assisted Living Facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney.

Directed Corrective Actions:

1. Employment of a consultant pharmacist to complete a full audit and review all medication systems in the Assisted Living Facility and ensure all medications are maintained and provided in a safe manner for the next six months. **This must be completed within 10 days of the date of this letter.**

2. Documentation that all staff in your facility that are administering or assisting in self-administration of medication to residents have been re-trained on correct medication practices by a licensed pharmacist or registered nurse. **This must be completed within 10 days of the date of this letter.**

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

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Phone:(305) 593-3100; Fax:(305) 593-3121
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Sunny Hills Of Homestead
, 2015

Should you have any questions, please contact . Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 Verlande Exil, Health Facility Evaluator Supervisor, Miami Field Office, at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve

D7JR

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