STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964518	07/15/2015
NAME OF PROVIDER OR SUPPLIER **SUNSHINE MEADOWS**	STREET ADDRESS, CITY, STATE, ZIP CODE **1809 18TH STREET** **SARASOTA, FL 34234**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

This is the Biennial and Limited Nursing Services (LNS) survey was conducted on through at Sunshine Meadows, an Assisted Living Facility (ALF) located in Sarasota, Florida.

0030 Resident Care - Rights & Facility Procedures

Based on resident and staff interviews, the facility failed to ensure resident rights related to access to money were provided for 4 (Residents #7, #8, #9, and #15) of the 10 residents interviewed and failed to ensure 1 (Resident #7) of the 10 residents interviewed received a diet are ordered by the physician.

The findings included:

1. During interviews, Residents #7, #8, #9 and #15 explained they have funds that are held in the business office. They said they can access those funds during the week, Monday through Friday, after 2:00 p.m. They said they cannot get to the money on the weekends.

During an interview on at 1:55 p.m. Employee D, Business Office Manager, said she is the one responsible for giving the residents their money. She said they can get their money after 2:00 p.m. during the week. If they need it before 2:00 p.m. because they are going out, like to a store or a movie, she'll give it to them, but other than that she adheres to giving it to them after 2:00 p.m. She said that is the way it has always been done. She said she works Monday through Friday. She said if the resident needs their money on Saturday or Sunday they can't have it because the business office is closed. If they are going to need money for the weekend, they will need to come to her on Friday.

2. Review of Resident #7's physician order dated revealed a prescribed diet for low fat/low salt diet. Resident has been getting a regular / no added salt diet as evidenced by the resident dietary list located in the kitchen and produced by Employee F, Dietary Cook. The facility has not been following the physician order for a specialty diet.

Class III

0031 Resident Care - Third Party Services

Based on 3 interviews with both residents and staff, the facility failed to ensure there was communication and coordination between the facility and a third party provider for 3 (Residents #2, #3 and #14) of the 3 residents receiving treatment at centers.

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The findings included:

1. Interviews conducted with Resident #2 on at 10:45 a.m., Resident #3 on at 11:16 a.m., and Resident #14 on at 4:30 p.m. revealed they all go to 3 days a week for treatments. All of the residents noted they go to the center before 6 a.m. on days. When questioned about breakfast being given Resident #2 stated she does not take anything with her for breakfast, Resident #3 also stated he doesn't take any thing for breakfast and Resident #14 indicated the same.

On at 12:05 p.m. during an interview the person in charge of the kitchen, employee F, stated he is sending breakfasts with Residents #2, #3, and #14. He does not know if they are taking it or not, he just he prepares it for the residents.

On at 2:07 p.m. the Director of Nurses indicated the residents are provided with food to go to with them, but she is unsure whether they take it or not. When questioned about the 6 a.m. medication for Residents #2 and #3 she stated the medication is given prior to regardless of whether the resident is eating or not. This drug is important for residents as it reduces some of the side products of food. However, it must be given with food to ensure the effectiveness of the drug. She agreed the drug was not being given to the residents to take when they are eating breakfast.

A review of Residents #2, #3, and #14's records revealed there was no documentation showing communication and coordination with the center.

Class III

0093 Food Service - Dietary Standards

Based on record review and interview, the facility failed to follow the specialty diet as ordered for 1 (Resident #7) out of 1 sampled resident.

The findings included:

Review of physician order for Resident #7 dated revealed a low fat and low diet. The order was not noted (signed off) by a nurse.

During an interview on at 11:45 a.m. Employee F, the Dietary Cook, said Resident #7 is on a regular/no added salt diet. He said if the there is a dietary change nursing is responsible for giving

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dietary services a dietary communication form informing them of the change. He confirmed the facility did not follow physician prescribed diet for Resident #7.

Interview with the Director of Nursing (DON) on at 1:00 p.m. confirmed the physician order dated for Resident #7 prescribing a low fat/low salt diet. She confirmed a nurse failed to note (sign off) on the order. She confirmed there is no dietary communication form in the resident's chart or in dietary services. She said a nurse should have noted the order and sent a dietary communication form to the kitchen.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observations made during tour of the facility between 10:00 a.m. and 11:30 a.m., it was determined that the facility failed to maintain a clean, safe, sanitary environment.

The findings included:

1. During the tour of the facility on observations in the ALF in #280 and #284, revealed the area between the air conditioner and window sill was observed to have black bio-growth on the dry wall. The air conditioner is located on an outside wall. This area consists of approximately 4 inches by four feet. It was observed rain water running down the window. This condition was created because the gutter above the window was over flowing due to an obstructed gutter. This condition allows rain water and moisture to enter the area in question due to the outside window is not properly sealed. This obstructed rain gutter condition was also noted in the beauty salon 10:30 a.m. In this area the water was not running down the window. The Centers for Control indicate that although there is no evidence that the presence of mold and mildew will cause in a healthy human, it will, to an immeasurable degree exacerbate any condition of or deficiency, compromise, or These conditions were observed by a Registered Nurse Health Surveyor, Life Safety Surveyor and Director of Maintenance during the tour.

2. During a tour of the facility on and confirmed by Employee A and and confirmed by the Director of Maintenance, the following was observed:

#29, #36, #39, #279, #283, #286's toilet bowl dark ring inside the bowl at the water mark or with dark colored streaks going down the inside of the bowl.
had a brown substance on call light cord.
had brown fecal matter on the toilet seat and toilet bowl.

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79's was dirty.
#285 and #286's shower stall rimmed with black substance at the floor.
#36, #67, #69, #70 and #278's ceiling vents had black substance on them.
#29 and #50's shower stall seat had a black substance on them.
#69, #282 and #286's had live roaches observed in the
had a strong odor of in the
30's call light not functioning properly; it would turn on and not turn off.
37's call light did not function properly; it would not turn on.
39's laminate around the sink base peeling off.

3. Resident #17 was observed laying on the bed on at 12 noon. The chair alarm attached to the wheelchair was not alarming. The resident stated its battery was and it had been for several days. The resident has a history of and tends to get up without help even when he is not supposed to.

Interview on at 12:30 p.m. with the Director of Nurses (DON) revealed she has no systematic way for the direct care staff to inform the nurses of the issues with the chair alarm. She said they have a book for maintenance to fix things, but nothing for nursing to ensure the alarms on 2 of the resident's chairs to remain in working order. She said the aides are supposed to report it to the nursed verbally.

Class III

0162 Records - Resident

Based on observation, record review and interview with staff, the facility failed to provide observation and documentation of resident behavior for 1 (Resident #4) of 6 resident records reviewed.

The findings include:

1. Resident #4 was observed during lunch on . During the time observed from approximately 11:32 a.m. to 12:15 p.m., the resident was sitting in a chair. Food was offered to her and the resident refused angrily. She swore at both the residents at her table, and the resident care aide (Staff E) present in the . The aide returned the resident's food to the cart to keep warm and served another resident their lunch. The resident began reaching across the table pulling their food to her. She took one of the resident's desserts and ate it using her fingers. She reached for the one of the other resident's water and juice. The aide brought both items to the resident and she thirstily drank both glasses. Whenever the resident was approached or spoken to by the other resident she swore at them and called them names in foul language. The resident care aide (Staff E) stated Resident #4 does not always behave this way, but she said she could never be sure when the behavior would happen. She also said this behavior

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happened intermittently.

Review of the resident's record revealed the resident is taking multiple medications. She take 0.5 mg for at 9:00 a.m. daily. She also takes a 25 mg at 5:00 p.m. and a long acting version of this medication also at 5:00 p.m. This medication is an medication. The resident also takes 50 mg every morning and (used to treat Additionally this resident can have a dose of injectable by injection 2 times a day for agitation. The documentation in the Medication Observation Record (MOR) for revealed the resident received this medication on and . The nurse noted the resident received this medication for but there was no documentation of any behaviors the resident was exhibiting at the time of injection.

Review of the resident's record revealed there was no documentation in the "nurse's notes" revealed there was no documentation of any behaviors the resident was exhibiting, and no assessment by the nurse of the resident's responses to medication other that "with effect" after the injectable was given.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Sunshine Meadows
1809 18th Street
Sarasota, FL 34234

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representatives 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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