RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sunshine Eldercare Of Miami Lakes Inc
6911 Bamboo St
Miami Lakes, FL 33014

Dear Administrator:

This letter reports the findings of a complaint 2015013198 survey conducted on / and concluded on /, by representatives of the Agency for Health Care Administration (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).

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

St - A - 0163 - 429.49 Fs - Records - Resident, Penalties For Alteration S-S= G
St - A - Z814 - 435.12(2)(b-D), Fs - Background Screening Clearinghouse S-S= C
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C
St - A - Z828 - 408.813(3) - Administrative Fines; Violations S-S= C

Directed Corrective Actions:

1. The facility shall ensure that it operates within its licensure capacity of six (6) beds. The facility shall provide 45 day notices to residents in order to maintain their licensed capacity. The facility shall ensure that all residents in the facility are assigned to a bed in a ; and retain and use their clothes and other personal property in their immediate living quarters. The facility may not violate any residents' rights and cannot deprive any resident of his/her ability to live in a safe and decent environment, free from punishment. **This shall be completed by** .

2. The facility must meet the minimum staffing requirements as identified by rule and as needed to meet the needs of the facility's residents. The staff employed must be properly background screened and reference checked prior to service provision, and must be properly trained according to Agency regulations and facility policies and procedures. The facility shall provide photographic proof of identification of staff member to verify identify and documentation must be present at the facility at all times for staff members. The facility must have an accurate schedule reflecting the staffing in the facility at all times. **This shall be completed on** .

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

Sunshine Eldercare Of Miami Lakes Inc
, 2016

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

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, (305) 593-3100

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve

D7JR

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968502	01/27/2016
NAME OF PROVIDER OR SUPPLIER **SUNSHINE ELDERCARE OF MIAMI LAKES INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6911 BAMBOO ST** **MIAMI LAKES, FL 33014**	

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

0000 Initial Comments

A complaint (CCR # 201513198) survey was conducted on / and concluded on /. Sunshine Eldercare Of Miami Lakes Inc with a Limited Mental Health component had the following deficiencies identified at time of the survey:

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to treat five of eight residents with dignity and respect (residents #'s 1, 3, 4, 6, 7) and ensure the residents were free from retaliation for two of eight residents (#s 1 and 2). The facility failed to ensure four of eight residents (#s 3, 4, 6 and 7) were not prevented from getting out of bed on their own through the use of walkers and wheelchairs placed against their beds which they could not remove.
Findings:
1. On / at 6:47 am Resident #1 was observed in a recliner in #. On / at 6:50 am, observed that there were no unassigned beds in the facility for Resident #1.
On / at 6:47 am, when asked where her bed was, Resident #1 stated, "This is my place for every day. I don't have a bed. I sleep here all the time."
On / at 6:47 am, the Administrator stated, Resident #1 had a bed, but just liked to sleep in the recliner.

2. On / / at 6:47 am, Residents #3, 4, 6 and 7 were observed to be restrained by walkers or wheelchairs placed alongside of their beds to prevent them from getting out.
On / at 6:25 am, Resident #3, who the Administrator reported did not live at the facility, was observed to be unable to respond when asked her name. The resident was unable to get out of bed without staff assistance.
On / at 6:48 am, Resident #4 stated that she could not remove the walker placed against her bed.

3. The Administrator arrived to the faiclity on / at 10:15 am, she stated, there were still eight residents since she had been told that she needed to give people 45 days' notice prior to discharging them. She said, two residents had been given 45 day notice. She stated, Resident #1, who was found sleeping in a recliner chair with no bed at the facility, was being discharged. She also stated, Resident #2 (admitted on /) was being discharged because she was "not a good fit" becasue she was the only English speaking resident.
Interview with Resident #1's family on / at 11:04 am revealed, resident #1 has been living there for more than two years and that she had been given 45 day notice to leave. The family member reported, she didn't understand why resident #1 had to leave after two years, when newer people weren't asked to leave. The family member reported, the Administrator did not give a reason for the 45

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day notice, but she believed it had to do with her mother telling the inspectors that she didn't sleep in a bed. The family member reported, resident #1 prefers the recliner, but the resident used to have a bed. The family member reported, it had been a while since there was a bed available resident #1. The bed had been unavailable for about a year. The family members, thought it was a temporary thing at first, but it never changed. The family members, didn't complain since resident #1 like the recliner.
4. Interview with Resident #2 on / at 12:05 pm revealed, she was asked to move, she reported, "they claim that my sister reported that they had more than 6 patients here." The Administrator told her, "I believe you were responsible and that you called them and told them I had 8 people. We've decided that it's best if you go. Here, now I'm down to 6."
Interview with Resident #2's family revealed, they believed resident #2 was being retaliated against. The family member reported, the Administrator yelled at resident #2 and stated that she called in the complaint conducted on / . The family member reported, the administrator made resident #2 sign the 45 day notice under duress.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation and interview, the facility failed to provide assistance with self-administration of medication in accordance with Statute 429.256 FS to eight of eight facility residents (Residents # 1-8). The Administrator pre-poured medications that were given to facility residents. The Administrator assisted Residents # 1 and #7 with medications without informing the residents of what they were taking.

Findings:

On / / at 7:06 am, pre-poured medications were observed in the medication cabinet, labeled by name for Residents # 1-7.
On / at 7:06 am, the Administrator stated, Resident #8 had already taken medications. The Administrator acknowledged having pre-poured the medications for all 8 residents.
On / at 7:52 am, observed the Administrator assisting Resident #7 take medications without informing the resident of what the medications were or reading the label.
On / at 8:56 am, observed the Administrator assisting Resident #1 take medications without informing the resident of what the medications were.
On / at 8:57 am, the Administrator acknowledged that she had not informed the residents of what the medications were.

Class III

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0054 Medication - Records

Based on record review and interview, the facility failed to ensure that medication observation records for three of eight facility residents (#4, #5, and #7) were signed/initialed after the medications were given to the residents.

Findings:

On / / at 10:30 am, record review revealed, Residents #4, 5 and 7's 8:00 am and 9:00 am had not been signed for.

On / / at 10:35 am, the Administrator stated, the residents had taken their medications and that they were just missing the signature.

Class III

0079 Staffing Standards - Levels

Based on observations and interview, the facility failed to have the minimum staff hours of 212 per week for a census of eight residents.

Findings:

On / / at 10:24 am, the staff schedule showed for / / one employee worked 7 am to 7 pm, a second employee worked 7 pm to 7 am, a third employee worked 9 am to 6 pm, and a fourth employee worked on the weekends 7 am to 7 am on both days. The list of employees on the staffing pattern showed three staff members and the staff members were written for multiple shifts. The facility's staffing pattern could not show the facility had a minimum of 212 hours per week for a census of eight residents.

The staff schedule was reviewed with the Administrator on / / at 12:44 pm, who stated she was going to correct the staff schedule to specify who worked which hours.

Class III

0081 Training - Staff In-Service

Based on record review and interview, the facility failed to ensure that one of five (Employee A) sampled staff members completed in-service training within 30 days of employment.

Findings:

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Record review found Employee A did not have 3 hours of activities of daily living (ADLs) and behavioral needs training, elopement training, emergency preparedness training, incident reporting training, or residents rights including recognizing/reporting , neglect, and .

On / / at 12:44 pm, the findings were revived with the Administrator who acknowledged that Employee A did not have the training.

Class III

0093 Food Service - Dietary Standards

Based on observations and interviews, the facility failed to have a menu posted so the residents could review the meal options.

Findings:

On / at 10:15 am, the Administrator stated Resident #2 speaks English only.

On / / at 11:43 am, the facility's menu posted was in Spanish. The facility did not have a menu available in English for residents to review.

On / at 12:05 pm, Resident #2 stated "the language barrier is incredible."

Class

0161 Records - Staff

Based on record review and interview, the facility failed to ensure that five of five (Employee A-E) sampled staff members had completed records at the facility.

Findings:

Record review found the Administrator, Employee A and C did not have completed applications with references. Record review found Employees B and D did not have any records at the facility.

On / / at 12:44 p, the findings were revived with the Administrator who acknowledged that employee records were not completed.

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Class III

0163 Records - Resident. Penalties for Alteration

Based on observations, record review, and interview, it was determined the facility falsified employee records for two of five (Employee B and D) sampled employee's who were at the facility during surveys providing care and services to a census of eight residents.

Findings:

1. On [redacted] at 6:25 am, observed Employee B in the kitchen at the facility. On [redacted] at 6:44 am, Employee B was observed in a resident [redacted], assisting Resident #6 as she got out of the shower and got dressed.
On [redacted] at 6:25 am, Employee B reported, she was Employee C and gave her name, but reported, she had no identification with her.
A review of the facility's personnel records revealed no documentation for Employee B including a level II background screening.
On [redacted] at 6:46 am, the Administrator stated, Employee B didn't work at the facility yet, because her background screening was not in place. But, Employee B was observed working with Resident #6.
A review of the Background Screening Database revealed, the woman identifying herself as Employee C on [redacted] did not match the photograph on file. Employee B had misrepresented herself as Employee C.

2. On [redacted] at 10:03 am, a woman who identified herself as Employee C was observed at the facility.
On [redacted] at 11:00 am, the woman who identified herself as Employee C, reported she did not have identification.
A review of the Background Screening Database revealed, the woman identifying herself as Employee C on [redacted] did not match the photograph on file.
On [redacted] at 11:00 am, the employee representing herself as Employee C was asked to state her date of birth, the date given by the woman identifying herself as Employee C did not match the birthdate on file in the background screening database.
It was determined this was not Employee C, but Employee D. Employee D had also misrepresented herself as Employee C.
A review of the facility's personnel records revealed no documentation for Employee D, including a level II background screening.

The facility did not have records for Employees B and D to include, a completed application with references, department of labor requirements for proof of identification, and training. The facility only had documentation for Employee C, who was not at the facility on during the [redacted] or [redacted] inspections.

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Record review found, the facility had Employee C listed on the staffing pattern. The facility did not have qualified staff to meet the staffing hours to care for a census of eight residents. The facility did not have a completed application for Employee C. The facility had the following in Employee C's record: First Aid and ( ) training, 2 hours of food service and nutrition, 2 hours of medication training, 4 hours of training, training, personal care and hygiene training, and (/) training, 2 hours of control training.
On / at 9:23 am, the Administrator stated, Employee D left last night and is no longer employed by the facility. She stated, Employee B left after the initial survey on / .

Class II

Z814 Background Screening Clearinghouse

Based on observation and record review, the facility failed to register with the clearinghouse and maintain the employment status of all employees within the clearinghouse.

Findings:

Arrived to the facility on / at 10:00 am, found Employees A and D working, caring for a census of eight residents.

Record review showed the staffing pattern reflected the facility had three staff members.

The background screening website showed the facility did not register its employees to the facility's roster.

Unclassified

Z815 Background Screening: Prohibited Offenses

Based on observation, record review, and interview, the facility failed to ensure that two of five employees (Employee B and D) obtained an eligible Level II Background screening prior to providing care and services to a census of eight residents.
Findings:
On / at 6:25 am, observed Employee B in the kitchen at the facility. On / at 6:44 am, Employee B was observed in a resident , assisting Resident #6 as she got out of the shower and got dressed.

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A review of the facility's personnel records revealed no documentation for Employee B including a level II background screening.
On 1/ at 6:46 am, the Administrator stated, that Employee B didn't work at the facility yet because her background screening was not in place. But employee was observed to be assisting resident #6.
On 1/ / at 10:03 am, Employee D was found in the facility assisting resident with activities of daily living.
A review of the facility's personnel records revealed no documentation for Employee D including a level II background screening.
Unclassified

Z828 Administrative Fines: Violations

Based on observation and interview, the facility exceeded its licensed capacity. The facility is licensed for six beds, however eight residents (Residents #1-8) were observed living in the facility.
Findings:
On 1/ / at 6:22 am, observed eight residents in the facility. Resident #1 was seated in a recliner in # 1. Five residents were asleep in beds. Resident #2 was eating breakfast. Resident #5 was standing in a shower stall.
On 1/ / at 6:47 am, Resident #1, who was observed in a recliner in # 1, was asked, where her bed was, she stated, " This is my place for every day. I don't have a bed. I sleep here all the time."
On 1/ / at 6:50 am, observed that there were no unassigned beds in the facility where Resident #1 could have been sleeping.
On 1/ at 6:30 am, Resident #8 was observed asleep in a garage that had been converted to a .
On 1/ at 6:31 am, Resident #8 stated that he lived at the facility.
On 1/ at 6:45 am, the Administrator stated, Resident #7 lived across the street with someone who took care of her, however her caregiver's parent had in Cuba and the resident had been at the facility for a week, waiting for the caregiver to return.
On 1/ at 6:45 am, the Administrator stated that Resident # 3 lived with her niece, but that she had been sleeping at the facility for a few days because her niece was out of the country.
On 1/ at 7:06 am, observed medications centrally stored in the facility's medication cabinet for residents #1-8.
Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sunshine Eldercare Of Miami Lakes Inc
6911 Bamboo St
Miami Lakes, FL 33014
RE: CCR #2015013198

Dear Administrator:

This letter reports the findings of a complaint licensure survey that was concluded on 27, 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** 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 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

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