RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sunshine Home Alf, Inc
4264 West 7 Lane
Hialeah, FL 33012

Dear Administrator:

This letter reports the findings of a Standard Biennial revisit survey conducted on 13, 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966272	R
NAME OF PROVIDER OR SUPPLIER **SUNSHINE HOME ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4264 WEST 7 LANE** **HIALEAH, FL 33012**	

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

0000 Initial Comments

A Standard Biennial Revisit Survey was conducted on 09/13/16. Sunshine Home ALF, License #10522, had the following deficiencies identified at time of the survey:

0052 Medication - Assistance with Self-Admin

Based on observation, record review, and interview, the facility failed to ensure that staff followed correct procedures while assisting residents with self-administration of medications for two out of four (#2 and #4) sampled residents.
Finding included:
Observation on at 9:05 AM found Resident #4 was having breakfast at the dining table, Staff B (caregiver) was assisting the resident with self-administration of medications. Staff B unlocked the kitchen cabinet took bingo card with medications: 50 MG, 20, 10 mg, 20 mg, therapeutic M, Vesicare 5 mg, 20 Mg, 5 MG. Staff B punched bingo card and drop pills onto a napkin. Staff B (caregiver) did not prompt or read the medication label to Resident #4. Staff B walked away and left Resident #4's medication on the table.
Further observations on at 9:34 AM found Staff B assisting Resident #2 with self-administration of medications. Staff B punched medication bingo card on to the tablecloth; medications: 10 mg, 1 mg, 20, 200 mg, 100 mg HCTZ 12.5 mg, 10 mg therapeutic M , 10, mg, 20 MG. Staff B (caregiver) did not prompt or read the medication label to Resident #2. Staff B walked away.
Record review on showed that medication observation record (MORs) was initialed by Staff B (caregiver) before Residents #2 and #4 swallowed their medications.
During an interview on / at 9:45 AM Staff B acknowledged deficiencies found. She stated, "you know what I do; in the morning I did go to the residents' . I make sure that they are OK. I come here to the table and initialed the MORs for all of them." She stated Residents take their medications after breakfast.
Class III

0079 Staffing Standards - Levels

Based on observations, record review, and interview the facility failed to have an updated written work schedule.
Findings included:
Observation on at 8:35 AM found Staff B (caregiver) assisting all residents with self-administration of medication bathing, dressing, and ambulating.
During an Interview on / at 9:27 AM, Staff C (caregiver) stated that she did not worked at the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966272	R
NAME OF PROVIDER OR SUPPLIER **SUNSHINE HOME ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4264 WEST 7 LANE** **HIALEAH, FL 33012**	

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

facility in the night time shift. She stated Staff B worked here 24 hours.
During an interview on at 9:30 AM, Staff B (caregiver) stated "I'm working here 24 hours, off Saturday and Sundays."
Review of the written work schedule posted found it was from Sunday, , 2016 to Saturday, , 2016 showed four staff members listed. Staff A-(administrator) 7:00 AM to 7:00 PM, Staff B (caregiver) 7:00 AM to 7:00 PM; Staff C (caregiver) 7:00 PM to 7:00 AM and Staff D (caregiver) 10:00 AM to 12:00 AM. The facility did not have a staffing schedule for the week of .
Uncorrected Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11966272 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME ALF, INC	4264 WEST 7 LANE HIALEAH, FL 33012

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0078	Correction	ID Prefix A0081	Correction	ID Prefix A0082	Correction
Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.0191(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0083	Correction	ID Prefix A0090	Correction	ID Prefix A0161	Correction
Reg. # 58A-5.0191(4) FAC	Completed	Reg. # 58A-5.0191(11) FAC	Completed	Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix AZ815	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 408.809, 435.02(2), 435.06	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
		9/26/16		
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/29/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		