STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910857	01/09/2017
NAME OF PROVIDER OR SUPPLIER **SUNSET LOVING CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **9740 SW 77 TERRACE** **MIAMI, FL 33173**	

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

0000 - Initial Comments

A Change of Ownership survey was conducted on / . Sunset Loving Care (Assisted Living Facility, License #5235) had deficiencies at the time of the survey.

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

Based on observation and interview the facility failed to follow the correct procedure when assisting 1 out of 5 sampled resident with self-administration of medications (Resident #2).

Findings Include:
On / at 11:45 AM Observed Staff C washed her hands, handed medication to Resident #2 in her hands without using gloves, staff grabbed medication with her hands and gave it to resident. The staff handed the water cup and did not state name of medication to resident.
On / at 11:58 AM Administrator stated, "Staff C has been trained on assistance with self-administered medication and we will go over the procedure again with her to make sure she does it correctly."
Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview the facility failed to maintain medication observation records (MORs) stating the time each medication is given to residents for 4 out of 5 sampled residents (Resident #1, #2, #3, #4).
Findings include:
Review of medication observation record book revealed there was no documentation of the time medications are given to residents. (Photo evidence)
On / at 11:48 AM Administrator stated " We were recording the medication record that way, but our consultant told us it was not necessary to document the time the medication was given. "
Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, record review, and interview the facility failed to maintain an accurate written work schedule.

Findings include:
On / at 7:07 AM, arrived to facility and was greeted by Staff C, staff was alone and was assisting a resident.
On / at 7:08 AM Staff C stated "Please wait and sit in the office, I am attending Resident#1 at

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the moment."
A review of staff schedule revealed Staff A was on schedule as working 7 AM to 7 PM.
On / at 7:22 AM Observed Staff A arrived to facility.
Class III

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

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based record review and interview the facility failed to have a current eligible Level II background screening for a staff with a break in service of more than 90 days.
Findings Include:
Record review of Staff C's employee file revealed staff was hired on / / . The last eligible Level II background screening was done on / /
On / / at 9:12 AM interview with Staff C stated, she worked in an assisted living facility in the year 2014 and that was her last job. Staff said she was at home for almost two years after she ended employment there.
Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Sunset Loving Care Inc
9740 Sw 77 Terrace
Miami, FL 33173

Dear Administrator:

This letter reports the findings of a Change of Ownerhsip licensure survey that was conducted on , 2017 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 , 2017.** 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 Arlene Mayo-Davis, RN.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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