STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965707	11/01/2018
NAME OF PROVIDER OR SUPPLIER **SUNFLOWERS VILLAGE II**	STREET ADDRESS, CITY, STATE, ZIP CODE **13295 SW 99 TERRACE** **MIAMI, FL 33186**	

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

0000 - Initial Comments

A Standard Biennial was conducted on and concluded on . Sunflowers Village II, license #10066, had the following deficiencies identified at the time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review, and interview the facility failed to discharge 1 out of 6 sampled residents who required a higher level of care (Resident #1). Resident #1 was bed bound and had a untreated , , which unlicensed staff was caring for without a doctor's order.

Findings included:

On at 9:20 AM observed Resident #1 in bed. The resident's left leg was amputated below the knee. Resident #1 had his back turned, and was naked from the waist down. Resident #1's was exposed and his upper near his sacrum, observed a which was red with observed on the disposable under , . Further observations found skin barrier creams on top of Resident #1's dresser. The creams were cream and skin protect cream.

On at 11:06 AM Resident #1 stated, "The staff clean the on my back for me for me every day. I get bathed in the bed, I am not able to get out of bed"

A review of Resident #1 hospital record showed the resident was admitted to the hospital on at 17:12 PM, hospitalization ordered by physician, inpatient admission. Preliminary diagnoses are of the right lower limb " is a common and potentially serious caused by . The the deep layers of skin and tissue beneath the skin." (American Academy of), chronic , with draining sinus, "A bone , it is mainly caused by and other germs." (MedlinePlus.Gov) right and , , of sacral region .

On at 9:27 AM Staff A (caregiver) stated, "Resident #1 is not receiving hospice services and he is not under any home health care." Staff A later reported on at 2:03 PM regarding Resident #1's , "Since it was something red that got worse than I thought applying the cream for protection was the best thing. I have been doing it for about a couple of weeks."

A review of Resident #1's notes revealed the facility did not have any documentation regarding the resident's . The last note documented was dated and stated "no significant changes

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965707	**11/01/2018**
NAME OF PROVIDER OR SUPPLIER **SUNFLOWERS VILLAGE II**	STREET ADDRESS, CITY, STATE, ZIP CODE **13295 SW 99 TERRACE MIAMI, FL 33186**	

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

have been noted at this time."

On at 9:47 AM the Administrator arrived to the facility she stated, "Resident #1 is not under hospice services, he just has a small redness and we have been applying cream for protection to the skin."

A review of Resident #1's file revealed there was no documentation of a physician's order to apply the skin protection cream. A review of Resident #1's health assessment revealed it was completed on and had the following diagnoses: , , and of the . Unsteady gait due to left leg amputation. Alert and oriented times 3. Standard and precautions. Requires assistance with all activities of daily living.

On at 10:15 AM nurse observations found Resident #1 in bed. He had a below knee amputation of the left leg; the right leg was observed with dark coloration and severe dryness with flakes as if the resident had but the diagnosis was not written in his health assessment. Resident #1 did not have an adult brief on and was naked from the waist down; the sacral area the skin looked macerated and had small lacerations.

On at 10:25 AM phone interview with Resident#1's physician revealed, "I was there on Thursday. He has , , and that is chronic.

On at 10:30 AM observed for half an hour, Resident #1 in his to get out of bed but the resident kept saying "They know I can transfer. I do not want now. I can't." On at 12:30 PM attempted once more to observed for the resident to transfer out of bed and he refused.

On at 12:15 PM a follow-up phone interview with Resident#1's physician revealed, "On Thursday he did not have the skin macerated and the lacerations."

On at 1:14 PM, Resident #1 was taken to the hospital by ambulance.

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS 429.27

Based on observation and interview, the facility failed to honor Resident's Rights. The facility failed to

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965707	11/01/2018
NAME OF PROVIDER OR SUPPLIER **SUNFLOWERS VILLAGE II**	STREET ADDRESS, CITY, STATE, ZIP CODE **13295 SW 99 TERRACE** **MIAMI, FL 33186**	

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

treat 1 of 6 sampled residents (Resident #2) with respect and due recognition of personal dignity and privacy. Resident #2 was left in a . . . . . the door completely open, sitting on the toilet, undressed from the waist down.

Findings:

On at 9:28 AM, observed Staff A assisting Resident #2 with toileting. Resident #2 was observed undressed from the waist down, sitting on the toilet. The . . . . . was open and the resident was left in plain view of ALF staff and other residents.

On at 2:50 PM in an interview the Administrator stated she did not know why Staff A left the resident in the . . . . . with the door open. She stated the staff would be retrained to recognized and respect resident's privacy.

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review and interview, the facility failed to develop a written policy or procedure ensuring the alternate power source can be effectively operated and maintained. The facility failed to obtain the required fuel to ensure that in the event of the loss of primary electrical power there is sufficient fuel readily available to maintain temperatures at or below 81 degrees for residents.

Findings:

On at 2:00 PM an environmental safety tour was conducted with the facility's Administrator, the facility did not have fuel onsite to power the power source for at least 48 hours.

On . . . . . a record review revealed that the facility did not acquire a service or have a process to maintain and test the alternate power source. Additionally, the facility did not develop written policies and procedures to ensure the facility could effectively and immediately operate and maintain the alternate power source and any fuel required for the operation of the alternate power source.

On at 2:50 PM in an interview, the Administrator stated she did not know the documentation/emergency plan information created by her consultant for her facility did not have written policies and procedures for testing, operating and maintaining the generator and fuel.

Class III