

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969378</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/12/2020</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**DAYI'S SUNFLOWERS ALF LLC**

**5739 RIDGESTONE DR  
TAMPA, FL 33625**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>A biennial survey was conducted at Dayi's<br>Sunflower Assisted Living Facility on 10/12/2020.<br>There were deficiencies at the time of the visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A 000               |                                                                                                                          |                          |
| A 010<br>SS=D            | 429.26( ) FS; 59A-36.006(4) FAC Admissions -<br>Continued Residency<br><br>429.26<br>(1) The owner or administrator of a facility is<br>responsible for determining the appropriateness<br>of admission of an individual to the facility and for<br>determining the continued appropriateness of<br>residence of an individual in the facility. A<br>determination must be based upon an evaluation<br>of the strengths, needs, and preferences of the<br>resident, a medical examination, the care and<br>services offered or arranged for by the facility in<br>accordance with facility policy, and any limitations<br>in law or rule related to admission criteria or<br>continued residency for the type of license held<br>by the facility under this part. The following<br>criteria apply to the determination of<br>appropriateness for admission and continued<br>residency of an individual in a facility:<br>(a) A facility may admit or retain a resident who<br>receives a health care service or treatment that is<br>designed to be provided within a private<br>residential setting if all requirements for providing<br>that service or treatment are met by the facility or<br>a third party.<br>(b) A facility may admit or retain a resident who<br>requires the use of assistive devices.<br>(c) A facility may admit or retain an individual<br>receiving hospice services if the arrangement is<br>agreed to by the facility and the resident,<br>additional care is provided by a licensed hospice,<br>and the resident is under the care of a physician<br>who agrees that the physical needs of the<br>resident can be met at the facility. The resident | A 010               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| A 010                    | <p>Continued From page 1</p> <p>must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.</p> <p>(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:</p> <ul style="list-style-type: none"> <li>a. Move, turn, or reposition without total physical assistance;</li> <li>b. Transfer to a chair or wheelchair without total physical assistance; or</li> <li>c. Sit safely in a chair or wheelchair without personal assistance or a physical</li> </ul> <p>2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.</p> <p>3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.</p> <p>(2). A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.</p> <p>(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not</p> | A 010               |                                                                                                                          |                          |

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AHCA Form 3020-0001  
STATE FORM

Agency for Health Care Administration

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| A 010                                                               | <p>Continued From page 3</p> <p>are met:</p> <ol style="list-style-type: none"> <li>1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;</li> <li>2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;</li> <li>3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,</li> <li>4. Documentation of the requirements of this paragraph is maintained in the resident's file.</li> </ol> <p>(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.</p> <p>(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.</p> <p>(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.</p> <p>(g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation, record review and interview, the facility failed to ensure one (Resident #1) of 2 residents sampled received a ...-to-... medical examination by a health care provider after a significant change.</p> | A 010                                                                          |                                                                                                                          |  |                                                        |

If continuation sheet 5 of 10

Agency for Health Care Administration

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| A 082                                                                | Continued From page 5<br><br>failed to ensure one (Staff C) out of two sampled staff had completed a one-time education course on and within 30 days of employment.<br><br>Findings Included:<br><br>Staff C's employee record was reviewed on . There was no and training in the employee file. Staff C's date of hire was .<br><br>Staff A was interviewed on at 1:00pm regarding the missing paperwork and acknowledged it was not in the employee files.<br><br>Class III                                                                                                                                                                                                                                                                       | A 082                                                                          |                                                                                                                          |                          |                                                        |
| A 162                                                                | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. .<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of other health insurance ,<br>8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and,<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule | A 162                                                                          |                                                                                                                          |                          |                                                        |

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| A 162                    | Continued From page 6<br><br>59A-36.006, F.A.C.<br>(c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.<br>(f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually.<br>(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.<br>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.<br>(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.<br>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.<br>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly | A 162               |                                                                                                                          |                          |

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| A 162                    | <p>Continued From page 7</p> <p>written statement of funds or other property disbursed as required in section 429.27, F.S.</p> <p>(l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____, CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a>. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.</p> <p>(m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.</p> <p>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.</p> <p>(o) The resident's _____, DH Form 1896, if applicable.</p> <p>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility:</p> <ol style="list-style-type: none"> <li>1. A log listing the names of residents participating in this arrangement,</li> <li>2. The resident demographic data required in this paragraph,</li> <li>3. The health assessment described in rule 59A-36.006, F.A.C.,</li> <li>4. The resident's contract described in rule</li> </ol> | A 162               |                                                                                                                          |                          |



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| A 162                                                               | <p>Continued From page 8</p> <p>59A-36.018, F.A.C.; and,</p> <p>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.</p> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to maintain hospice records and Interdisciplinary Care plan on premises for 3 (Resident #2, #3 and #6) of 3 residents sampled.</p> <p>Findings Included:</p> <p>A resident record review conducted on revealed Residents #2, # 3 and # 6 were receiving Hospice services. Hospice records and Interdisciplinary Care plan were unavailable for review upon request.</p> <p>During an interview with Administrator on at 11:10am, she stated all hospice records and the interdisciplinary care plans are maintained in a hospice book. She stated she had called the facility's owner and he said the</p> | A 162                                                                          |                                                                                                                          |                          |                                                        |

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| A 162                    | <p>Continued From page 9</p> <p>hospice book should have been in the facility unless the hospice nurse had taken it. The Administrator stated she had looked for the book and could not find it.</p> <p>During an Interview conducted on _____ at 12:55 pm with the Administrator, she confirmed the Hospice book was not in the facility and the facility did not have an interdisciplinary care plan on _____.</p> <p>Class III</p> | A 162               |                                                                                                                          |                          |

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| CZ816                    | <p>408.809(2a-c) 435.05(2) 59A-35.090(2d-3c)<br/>Background Screening-Compliance Attestation</p> <p>408.809 Background screening; prohibited offenses.-</p> <p>(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's _____ to the Federal Bureau of Investigation for a national criminal history record check unless the person's _____ are enrolled in the Federal Bureau of Investigation's national retained print _____ notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print _____ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person _____. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or</p> | CZ816               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |                          |                                                        |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969378</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/12/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DAY'S SUNFLOWERS ALF LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5739 RIDGESTONE DR<br/>TAMPA, FL 33625</b>                                   |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| CZ816                                                               | <p>Continued From page 1</p> <p>professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:</p> <p>(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;</p> <p>(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and</p> <p>(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.</p> <p>435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:</p> <p>(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if _____ for any of the disqualifying offenses while employed by the employer.</p> <p>59A-35.090 Background Screening.</p> <p>(2) Processing Screening Requests, Required Documents and Fees.</p> <p>(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, _____, herein incorporated by reference, available at <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-09106">http://www.flrules.org/Gateway/reference.asp?No=Ref-09106</a>, and available from the Agency for Health Care Administration at: <a href="http://ahca.myflorida.com/MCHQ/Central_Service">http://ahca.myflorida.com/MCHQ/Central_Service</a></p> | CZ816                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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| CZ816                                                               | <p>Continued From page 2</p> <p>s/Background_Screening/Regulations_Forms.sht<br/>ml. This form must be completed by the individual<br/>and retained by the provider upon hire to attest<br/>that they meet the requirements for qualifying for<br/>employment, they have not been unemployed for<br/>more than 90 days from a position that requires<br/>Level 2 screening, and they agree to inform the<br/>employer immediately if _____ for any<br/>disqualifying offense.</p> <p>(e) An administrator or chief financial officer must<br/>be screened and qualified prior to _____ to<br/>the position.</p> <p>(3) Results of Screening and Notification.</p> <p>(a) Final results of background screening<br/>requests will be provided through the Agency's<br/>secure website that may be accessed by all<br/>health care providers applying for or actively<br/>licensed through the Agency that are registered<br/>with the Care Provider Background Screening<br/>Clearinghouse. The secure website is located at:<br/>apps.ahca.myflorida.com/SingleSignOnPortal.</p> <p>(b) If a Level 2 criminal history is incomplete, a<br/>certified letter will be sent to the individual being<br/>screened requesting the _____ report and court<br/>disposition information. If the letter is returned<br/>unclaimed, a copy of the letter will be sent by<br/>regular mail. Pursuant to section 435.05(1)(d),<br/>F.S., the missing information must be filed with<br/>the Agency within 30 days of the Agency's<br/>request or the individual is subject to<br/>disqualification in accordance with section<br/>435.06(3), F.S.</p> <p>(c) The eligibility results of employee screening<br/>and the signed Attestation referenced in<br/>subsection 59A-35.090(2), F.A.C., must be in the<br/>employee's personnel file, maintained by the<br/>provider.</p> <p>This Statute or Rule is not met as evidenced by:</p> | CZ816                                                                                  |                                                                                                                          |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969378</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/12/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**DAYI'S SUNFLOWERS ALF LLC**

**5739 RIDGESTONE DR  
TAMPA, FL 33625**

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|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| CZ816                    | <p>Continued From page 3</p> <p>Based on record review and interview, the facility failed to ensure two (Staff B and Staff C) out of two sampled staff had a signed Attestation of Compliance in the employee's personnel file, maintained by the provider.</p> <p>Findings Included:</p> <p>Staff B's employee record was reviewed on . There was no signed Attestation of Compliance in Staff B's employee file.</p> <p>Staff C's employee record was reviewed on . There was no signed Attestation of Compliance in Staff C's employee file.</p> <p>Staff A was interviewed on . . . . . at 1:00pm regarding the missing paperwork and acknowledged it was not in the employee files.</p> <p>Unclassified</p> | CZ816               |                                                                                                                          |                          |