STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964404	**07/24/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunnydays Alf, Inc	**169 N.E. Prima Vista Blvd. Port Saint Lucie, FL 34983**	

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

0000-Initial Comments
An Assisted Living Facility biennial standard relicensure survey with Limited Nursing Services (LNS)was conducted on . Sunndays ALF, Inc. had a licensure deficiency found at the time of the visit.

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based interview and record review, it was determined the facility failed to appoint a core-trained Manager to this facility when the Administrator supervised more than one assisted living facility.

The findings included:

During an interview conducted at 9:20 AM, the Administrator stated she was the Administrator for two assisted living facilities; also confirmed through record review. The Administrator was asked to provide documentation indicating the person to whom she designated as the facility's Manager. She revealed that she did not have a core-trained Manager appointed for this facility in writing; she was not aware it was required.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Sunnydays ALF, Inc
169 N.E. Prima Vista Blvd.
Port Saint Lucie, FL 34983

Dear Administrator:

This letter reports the findings of a Limited Nursing Services licensure survey that was conducted on 2013 by representatives 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 (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State Form 5000-3547
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924