STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966029	**08/23/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunny Residence, Inc	**9001 Sw 20th Street Miramar, FL 33025**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Assisted Living Facility Relicensure and Limited Nursing Services (LNS) survey was conducted on [redacted] Sunny Residence, had a deficiency found at the time of the visit.

At the time of the visit, there were no residents receiving LNS.

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on interview and record review, the facility failed to maintain regular and therapeutic menus with substitutions on file for 6 months.

The findings include:

Review of the posted menu for lunch on [redacted] included Salisbury steak, potatoes, and vegetables. On [redacted] at approximately 11:00 AM during an interview with the Administrator, she stated that substitutions of tuna fish sandwich, vegetable soup and fresh fruit would be served for the lunch meal. She stated that she posts the meal substitutions next to the posted weekly menu but she does not maintain a file of the menu substitutions for the required 6 month period. She also confirmed the facility has had substitutions to the approved menu within the last 6 months. She acknowledged surveyor ' s findings and stated no further documentation was available for review.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Sunny Residence, Inc
9001 SW 20th Street
Miramar, FL 33025

Dear Administrator:

This letter reports the findings of a state licensure and Limited Nursing Services (LNS) survey that was conducted on 2013 by a representative from 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

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