AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942703	01/20/2016
NAME OF PROVIDER OR SUPPLIER **SUNNY BOWER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1604 71ST STREET NW** **BRADENTON, FL 34209**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

On 1/ a Biennial relicensure survey was conducted in conjunction with a Complaint survey (CCR2015012865). The Sunny Bower assisted living facility had deficiencies identified during the Biennial survey.

0010 Admissions - Continued Residency

Based on interview and record reviews, the facility failed to ensure that 1 of 2 residents reviewed (Resident #2) was appropriate for continued residency as evidenced by the lack of a face-to-face medical examination being completed by a health care provider at least every 3 years or with a change in condition.

Findings include:

Resident #2 was admitted to there facility on /_/_. A face to face medical examination was conducted on /_/ and was documented on the AHCA Form 1823 Health Assessment. No face to face examination has been completed and documented by a health care provider since . The resident has experienced a change in condition and was admitted to Hospice on .

An interview with the Administrator was conducted on 1/_/_ at 2:00 PM. She stated that she was not aware that a new assessment had not been completed for Resident #2, but that the resident has been seen by a health care provider.

CLASS III

0078 Staffing Standards - Staff

Based on interview and record reviews, the facility failed to ensure that 4 of 4 staff (#A,B,C & D) were free from signs or symptoms of a communicable including , as evidenced by a statement from a health care provider on an annual basis.

Findings include;

The last written statement of freedom from communicable , including for Staff A was /_/_.

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942703	01/20/2016
NAME OF PROVIDER OR SUPPLIER **SUNNY BOWER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1604 71ST STREET NW** **BRADENTON, FL 34209**	

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

There was no evidence of a negative examination having been completed for Staff B, who was hired on / .

There was no evidence of a negative examination having been completed for Staff C, who was hired on / .

The last documented evidence of a negative examination or freedom from communicable statement for Staff D was / .

An interview with the Administrator revealed that an appointment is scheduled for all staff to have tests completed this month.

CLASS III

0079 Staffing Standards - Levels

Based on interviews, observations and record reviews, the facility failed to maintain minimum staffing hours for the number of residents in the facility.

Findings included:

A review of the resident census for the months of ,2015, 2015 and 2016, revealed that the facility generally has a census of 14 residents and approximately 4 day care residents at one time or another from Monday through Friday. The facility is licensed for 16 residents and is approved to accept day care residents. An interview with the administrator also revealed that the facility has 7 participants in their day care program. The minimum staffing hours required for 16-25 residents is 253 hours.

During the month of 2015 the weekly staffing hours totaled 253.50.
During the month of 2015 the weekly staffing hours totaled 304.
During the month of 2016 the scheduled weekly staffing hours totaled 215.
At least 2 of the staff included in the hours are not trained in direct care of residents.

Observations were made throughout the day of the survey. There were 14 assisted living residents in the facility and 4 day care participants. There were 2 trained direct care staff in the facility, (the Administrator and Staff D). The housekeeper and Activity Director (not trained in direct care) were observed assisting Staff D with preparing, serving and assisting residents with the noon meal. Staff D

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942703	01/20/2016
NAME OF PROVIDER OR SUPPLIER **SUNNY BOWER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1604 71ST STREET NW** **BRADENTON, FL 34209**	

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

was also assisting residents with assistance with self administration of medications. 3 residents needed hands on assistance with feeding. Most of the residents in the facility have diagnoses of . Only 1 resident was capable of being interviewed. All of the assisted living residents require some kind of assistance from staff for their activities of daily living.

An interview was conducted with Staff D at 11:00 A.M. on . Staff D stated that she has worked in the facility for 10 years and that she has worked all shifts. She stated that she is used to the schedule but that it is a little more difficult with the added day care participants in the facility. She said that the facility used to have another person working during the noon meal which helped. She confirmed that most of the 14 residents require assistance with toileting, bathing and .

An interview was conducted with the Administrator at approximately 2:30 P.M. She confirmed that they used to have 1 additional staff person to assist with resident care until very recently and that based on the residents needs, she feels that they need to hire another person.

CLASS III

0082 Training -

Based on interview and record reviews, the facility failed to ensure that 1 of 4 staff whose records were reviewed had completed an education course on and (Staff C).

A review of the personnel file for Staff C (hired on), revealed no evidence of training in or .

Interview with the Administrator on confirmed this.

CLASS III

0085 Training - Nutrition & Food Service

Based on interview and record review, the facility failed to ensure that the person responsible for food service and supervision of food service staff had obtained 2 hours of continuing education on an annual basis.

Findings include:

A review of the personnel file of the Administrator (Staff A) revealed no evidence of annual continuing

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942703	01/20/2016
NAME OF PROVIDER OR SUPPLIER **SUNNY BOWER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1604 71ST STREET NW** **BRADENTON, FL 34209**	

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

education in food service topics. The last training received was dated / .

Interview with Staff A revealed that she is the person responsible for the food service in the facility and that she was unaware that she did not have current training.

CLASS III

0090 Trainina -

Based on interview and record reviews, the facility failed to ensure that 1 of 4 direct care staff had received 1 hour of training in the facility's policies and procedures regarding _ _ _ _'s. (Staff B).

Findings include;

During a review of the personnel file for Staff B, it was determined that there was no evidence that Staff B had been trained in the facility's policies and procedures related to _ _ _ _'s.

Interview with the Administrator confirmed this after she also reviewed the personnel file for Staff B for evidence of training.

CLASS III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sunny Bower
1604 71st Street Nw
Bradenton, FL 34209

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 2016 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 , 2016.** 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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com