STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968077	03/30/2017
NAME OF PROVIDER OR SUPPLIER **SUNNY DAYS ADULT CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1767 ORCHID CT NW** **PALM BAY, FL 32907**	

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

0000 - Initial Comments

On , 2017 a complaint investigation (2017003477) with Limited Mental Health (LMH)was conducted. Sunny Days Adult Care Inc., license #12027, had deficiencies at the time of the investigation.

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

Based on observations, record reviews and interview, the facility retained 1 of 5 residents (#5) who exceeded the Assisted Living Facility (ALF) residency criteria.

Findings:

Observations during a tour of the facility on at 1:10 PM revealed resident #5 was lying in his bed and he was unable to transfer or stand on his own.

On at 2 PM, the administrator said resident #5 required total assistance with his activities of daily living (ADLs), including bathing, dressing, , and toileting, and he required total assistance of two staff to transfer him from the bed. She said he required total assistance when he was admitted to the facility.

Resident #5's record revealed he was admitted to the facility on . A health assessment 1823 form, dated , revealed he had a medical history and diagnoses of , right sided , , , and required assistance with all of ADLs, including transfers.

On at 7 PM, non-emergency transportation arrived to transport resident #5 to the hospital for evaluation. Observations revealed he required three emergency medical services personnel to turn him over in the bed. He was unable to assist with bed mobility and was unable to use his right arm and hand.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observations, record reviews and interview, the facility failed to notify the health care provider when a resident developed , , and failed to obtain care orders from a health care provider for 1 of 5 sampled residents (#5).

Findings:

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On at 7 PM, non-emergency transportation arrived to transport resident #5 to the hospital for evaluation. Observation revealed he required three emergency medical services personnel to turn him over in the bed. He was unable to assist with bed mobility and was unable to use his right arm and hand.

Observations on at 7:10 PM revealed resident #5 had a sized on his , and a crescent shaped , approximately 2 centimeters (cm) x 0.5 cm, to his left .

Record review for resident #5 revealed a health assessment 1823 form, dated , that revealed he had to his and area. There was no documentation on the 1823 form or elsewhere in his record to reflect he had to his and left . There was no documentation in his record to reflect a health care provider was notified that he had , and there was no documentation that care orders were obtained from the health care provider. Resident #5's 1823 form read that he required assistance with all of his activities of Daily Liing (ADL's), including transfers.

On at 8 PM, the administrator confirmed resident #5 had the , and confirmed a health care provider was not notified of the , . She said the resident was admitted to the facility with the , .

Class II

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

Based on observations, interviews and record reviews, the facility failed to honor the resident's rights, and did not issue a 45-day notice of relocation or termination of residency for 5 of 5 residents (#1, 2, 3, 4 & 5).

Findings:

On the morning of , the facility owner called the Department of Children and Families (DCF) and the Agency for Health Care Administration (AHCA). She told them she wanted someone to come to the facility and remove all of the residents because she was going to close the facility effective immediately.

Upon entering the facility on at 1 PM, the owner was present and said she was glad a representative of AHCA was there to remove the residents. She said she did not tell the residents she

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was closing the facility, and she did not give the residents a notice to move. She said she decided that morning that she wanted to close the facility. She said it was just "too much" for her, and she was "about to have a nervous breakdown". She said she told the residents and their family members a month ago that she was thinking about closing the facility but then told them all she changed her mind. She said there were five residents who lived at the facility and identified three of them who received limited mental health services. A tour of the facility revealed the presence of five residents.

During a phone conversation with the AHCA supervisor on at 1:30 PM, the owner said she told the AHCA supervisor she would not agree to retain the residents to provide them a proper discharge notice and that if someone from AHCA did not come on that day to remove the residents, AHCA would be responsible for anything that happened. After she hung up the phone, she said she was shaking and tingling all over.

When questioned whether the residents were able to temporarily stay with a family member, she said she spoke with the residents' families a month ago, she considered closing the facility, but none of the family members were able to take the residents home with them. At 2:30 PM, she began calling all of the family members to tell them she was closing immediately, and to ask if they would come pick up the residents.

At approximately 3:30 PM, an adult protective investigator and police officer arrived at the facility.

At 4:05 PM, the father of resident #1 arrived at the facility. He said the owner told him a month ago that she was closing the facility at the end of , then she called him the next day and said she wasn't closing. He said he just found out today she was closing the facility. He said resident #1 lived at the facility for almost 7 years.

At approximately 4:30 PM, two DCF personnel arrived at the facility to assist with finding alternative placement for the residents.

Observation at 5:30 PM revealed resident #1 standing in the kitchen. He repeatedly said it was not fair that he had to move, and that all of his belongings were in the facility. He began removing his personal items from his , one item at a time, while walking backwards only, carrying each item outside. Observation revealed his agitation and levels rose over time. He repeatedly said he did not understand why this was happening.

Record review for resident #1 revealed he was admitted to the facility on . A health assessment form 1823, dated , reflected he had diagnoses of , and ,

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. Observations of his styrofoam plates, some with old food on them, piled high in stacks around his bed.

At 6:55 PM, resident #2 was accepted by another Assisted Living Facility (ALF), and left the facility in a private car.

Resident #2's record revealed he was admitted to the facility on . A health assessment form 1823, dated , reflected he had a medical history and diagnoses of and mild

At 6:56 PM, resident #1 was accepted by another ALF and he left the facility in a private car.

Resident #5 required total assistance with his activities of daily living, including transfers and was inappropriate for ALF placement. At 7:13 PM, he was transported via non-emergency ambulance to be evaluated and possibly transferred to a higher level of care. Review of his record revealed he was admitted to the facility on .

At 7:15 PM, observations revealed residents #3 and #4 pacing back and forth from the back porch to their and to the living . They repeatedly expressed fear that everyone was leaving. They would walk up to different people and ask if someone would take them home with them. They both packed their belongings in bags and brought them in and out of the living .

Resident #3's record revealed she was admitted to the facility on . A health assessment form 1823, dated , reflected she had a diagnoses of .

Resident #4's record revealed she was admitted to the facility on , and revealed the presence of a mental health community living support plan.

At 7:42 PM, resident #3 was accepted by another ALF, and she left the facility in a private car.

At 8:52 PM, resident #4 was accepted by another ALF and left the facility with one of the DCF personnel for transport to the accepting ALF.

Class I

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observations, record reviews and interviews, the administrator did not oversee the operation

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and management of the facility to prevent the systemic breakdown of facility operations and did not ensure the facility provided the necessary care to the residents: by failing to give a 45-day notice that the facility was closing for 5 of 5 sampled residents (#1, 2, 3, 4 & 5). In addition, the administrator did not provide care and services for two [redacted] for 1 of 5 residents (#5) and retained an inappropriate resident in the facility who could not transfer for 1 of 5 sampled residents (#5). The administrator failed to notify the Agency for Health Care Administration (AHCA) within 30 days that the facility was closing.

Findings:

1. The administrator failed to honor the resident' rights when she did not provide them with a 45-day notice of discharge, as required.

On the morning of [redacted], the facility owner called the Department of Children and Families (DCF) and the Agency for Health Care Administration (AHCA), and said she wanted someone to come to the facility and remove all of the residents because she was going to close the facility effective immediately.

Upon entering the facility on [redacted] at 1 PM, the facility owner was present and said she was glad a representative of AHCA was there to remove the residents. She said she did not tell the residents she was closing the facility, and she did not give the residents a notice to move. She said she decided just that morning that she wanted to close the facility. She said it was just "too much" for her and was "about to have a nervous breakdown". She said she told the residents and their family members a month ago that she was thinking about closing the facility but then told them all she changed her mind. She said there were five residents who lived at the facility, and identified three of them who received limited mental health services. A tour of the facility revealed the presence of five residents.

During a phone conversation with an AHCA supervisor on at 1:30 PM, the owner said she told the AHCA supervisor she would not agree to retain the residents to provide them a proper discharge notice, and that if someone from AHCA did not come on that day to remove the residents, AHCA would be responsible for anything that happened. After she hung up the phone, she said she was shaking and tingling all over.

When questioned whether the residents were able to temporarily stay with a family member, she said she spoke with the residents' families a month ago when she considered closing the facility, but none of the family members were able to take the residents home with them. The suggestion was made that she call the family members again on the day of the survey. At 2:30 PM, she began calling all of the family members to tell them she was closing immediately, and to ask if they would come pick up the residents.

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At approximately 3:30 PM, an adult protective investigator and police officer arrived at the facility.

At 4:05 PM, the father of resident #1 arrived at the facility. He said the facility owner told him a month ago that she was closing the facility at the end of , then called him the next day and said never mind. He said he just found out today she was closing the facility. He said resident #1 lived at the facility for almost 7 years.

At approximately 4:30 PM, two DCF personnel arrived at the facility to assist with finding alternative placement for the residents.

Observation at 5:30 PM revealed resident #1 standing in the kitchen. He repeatedly said it was not fair that he had to move, and that all of his belongings were in the facility. He began removing his personal items from his , one item at a time, and while walking backwards only, carried each item outside. Observations revealed his agitation and levels rose over time. He repeatedly said he did not understand why this was happening.

Resident #1's record revealed he was admitted to the facility on . A health assessment form 1823, dated , reflected he had diagnoses of , and . Observations of his styrofoam plates, some with old food on them, piled high in stacks around his bed.

At 6:55 PM, resident #2 was accepted by another assisted living facility (ALF), and left the facility in a private car.

Resident #2's record revealed he was admitted to the facility on . A health assessment form 1823, dated , reflected he had a medical history and diagnoses of and mild

At 6:56 PM, resident #1 was accepted by another ALF, and left the facility in a private car.

Resident #5 required total assistance with activities of daily living, including transfers and was inappropriate for ALF placement. At 7:13 PM, he was transported via non-emergency ambulance to be evaluated and possibly transferred to a higher level of care. Review of his record revealed he was admitted to the facility on .

At 7:15 PM, observations revealed residents #3 and #4 pacing back and forth from the back porch to

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their and to the living . They repeatedly expressed fear that everyone was leaving. They walked up to different people, and asked if someone would take them home with them. They both packed their belongings in bags and brought them in and out of the living .

Resident #3's record revealed she was admitted to the facility on . A health assessment form 1823, dated , reflected she had a diagnoses of , .

Record review for resident #4 revealed she was admitted to the facility on , and revealed the presence of a mental health community living support plan.

At 7:42 PM, resident #3 was accepted by another ALF, and she left the facility in a private car.

At 8:52 PM, resident #4 was accepted by another ALF, and left the facility with one of the DCF personnel for transport to the accepting facility.

2. The administrator retained a resident who no longer met the requirements to reside in an ALF.

Observations during a tour of the facility on at 1:10 PM revealed resident #5 in his bed.

During an interview with the administrator on at 2 PM, she said resident #5 required total assistance with ADLs, including bathing, dressing, , and toileting, and required total assistance of two staff to transfer him from the bed. She said he required total assistance when he was admitted to the facility.

Resident #5's record revealed he was admitted to the facility on . A health assessment 1823 form, dated , revealed he had a medical history and diagnoses of , right sided , , , and required assistance with all of his ADLs, including transfers.

On at 7 PM, non-emergency transport arrived to transport resident #5 to the hospital. Observation revealed he required three emergency medical services personnel to turn him over in the bed. He was unable to assist with bed mobility, and was unable to use his right arm and hand.

3. The administrator failed to ensure a health care provider was notified when a resident developed a , , and failed to obtain care orders from a health care provider.

On at 7 PM, non-emergency transportation arrived to transport resident #5 to the hospital. Observation revealed he required three emergency medical services personnel to turn him over in the

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bed. He was unable to assist with bed mobility ,and was unable to use his right arm and hand.

Observations on at 7:10 PM revealed resident #5 had a , sized , on his and a crescent shaped , approximately 2 cm x 0.5 cm, to his left .

Resident #5's record revealed a health assessment 1823 form, dated , revealed he had to his and , area. There was no documentation on the 1823 form or elsewhere in his record to reflect , on his and left . There was no documentation in his record to reflect a health care provider was notified that he had , , and no documentation that care orders were obtained.

During an interview with the administrator on at 8 PM, she confirmed resident #5 had the , , and confirmed a health care provider was not notified. She said he was admitted to the facility with the , .

4. The administrator failed to notify AHCA of her plan to close the facility at least 90 days prior to closure. The administrator/owner called AHCA at approximately 9:35 AM on , and stated all the residents needed to be "gone by today". She stated that she would drop them off at a shelter. It was explained to the administrator that she needed to give the residents a 45-day notice but she stated that she did not care. She expalined that she could not do this anymore, and she did not have the money to pay staff.

Class I

L242 - LMH - Responsibilities of Facility - 429.075(2) FS; 58A-5.029(3) FAC

Based on observations, record reviews and interview, the facility failed to record resident behaviors and functioning in the facility for 3 of 5 residents (#1, 3 & 4) who were identified as limited mental health residents.

Findings:

The facility administrator identified residents #1, #3, #4, and said they all received limited mental health services.

Record review for residents #1, #3, #4 did not contain documentation of any behaviors and functioning in the facility, as required.

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During an interview with the administrator on . . . . at 8 PM, she confirmed there was no documentation in any of the resident records to reflect their behaviors and functioning in the facility.

Class III

Z817 - Minimum Licensure Requirement - Inform AHCA - 408.810(3-4) FS; 59A-35.100(1) FAC

Based on observations, record reviews and interview, the facility failed to notify the Agency for Health Care Administration (AHCA) at least 30 days in advance of the Assisted Living Facility (ALF) closure.

Findings:

On the morning of , the facility owner called the Department of Children and Families (DCF) and AHCA, and said she wanted someone to come to the facility and remove all of the residents because she was going to close the facility effective immediately.

Upon entering the facility on at 1 PM, the facility owner was present, and said she was glad a representative of AHCA was there to remove the residents. She said she did not tell the residents she was closing the facility, and did not give the residents a notice to move. She said she decided just that morning that she wanted to close the facility. She said it was just "too much" for her and said she was "about to have a nervous breakdown". She said she told the residents and their family members a month ago that she was thinking about closing the facility but then told them all she changed her mind. She said there were five residents who lived at the facility and identified three of them who received limited mental health services. A tour of the facility revealed the presence of five residents.

During a phone conversation with an AHCA supervisor on . . . . at 1:30 PM, the owner said she would not agree to retain the residents to provide them a proper discharge notice, and that if someone from AHCA did not come on that day to remove the residents, AHCA would be responsible for anything that happened. After she hung up the phone, she said she was shaking and tingling all over.

When questioned whether the residents were able to temporarily stay with a family member, she said she spoke with the residents' families a month ago when she considered closing the facility but none of the family members were able to take the residents home with them. The suggestion was made that she call the family members again at the time of the survey. At 2:30 PM, she began calling all of the family members to tell them she was closing immediately, and to ask if they would come pick up the residents.

At approximately 3:30 PM, an adult protective investigator and police officer arrived to the facility.

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At 4:05 PM, the father of resident #1 arrived to the facility. He said the facility owner told him a month ago that she was closing the facility at the end of , then she called him the next day and said never mind. He said he just found out today she was closing the facility. He said resident #1 lived at the facility for almost 7 years.

At approximately 4:30 PM, two DCF personnel arrived to the facility to assist with finding alternative placement for the residents.

Observation at 5:30 PM revealed resident #1 standing in the kitchen. He repeatedly said it was not fair that he had to move and that all of his belongings were in the facility. He began removing his personal items from his , one item at a time, and while walking backwards only, he carried each item outside. Observations revealed his agitation and , levels increased over time. He repeatedly said he did not understand why this was happening.

Resident #1's record revealed he was admitted to the facility on . A health assessment form 1823, dated , reflected he had diagnoses of , and , . Observation of his styrofoam plates, some with old food on them, piled high in stacks around his bed.

At 6:55 PM, resident #2 was accepted by another assisted living facility (ALF), and left the facility in a private car.

Resident #2's record revealed he was admitted to the facility on . A health assessment form 1823, dated , reflected he had a medical history and diagnoses of and mild , .

At 6:56 PM, resident #1 was accepted by another ALF, and left the facility in a private car.

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At 7:15 PM, observations revealed residents #3 and #4 pacing back and forth from the back porch to their and to the living . They repeatedly expressed fear that everyone was leaving. They walked up to different people and asked if someone would take them home with them. They both

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packed their belongings in bags and brought them in and out of the living .

Resident #3's record revealed she was admitted to the facility on . A health assessment form 1823, dated , reflected she had a diagnoses of , .

At 7:42 PM, resident #3 was accepted by another ALF, and left the facility in a private car.

Resident #4's record revealed she was admitted to the facility on , and revealed the presence of a mental health community living support plan.

At 8:52 PM, resident #4 was accepted by another ALF, and left the facility with one of the DCF personnel for transport to the accepting facility.

Unclassified