STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922273	**04/12/2018**
NAME OF PROVIDER OR SUPPLIER **SUNNYSIDE MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **5201 BAHIA VISTA STREET** **SARASOTA, FL 34232**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced biennial survey was conducted through at Sunnyside Manor, an assisted living facility (license #7952) in Sarasota, Florida.

The following is description of the deficiencies.

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review, and interview, the facility failed to ensure a complete admission packet was available for new admissions to the facility. Failure to provide a complete admission packet leads to a lack of necessary information and may lead to misunderstanding between the resident or their representative and the facility.

The findings included:

1. Record review of the facility's admission packet revealed that the following information was not included:
a. The facility's admission and continued residency criteria;
b. The daily, weekly or monthly charge for Limited Nursing services (LNS) and list of all services provided;
c. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any;
d. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any;
e. The facility's resident elopement response policies and procedures;
f. Admission and retention policy;
g. policy;
h. Medication storage policy;
i. Elopement policy;
j. Reporting , neglect, and policy;
k. Administration scheduled availability;
l. control, sanitation, and universal precaution policy;
m. Third party coordination policy (including coordination of communications);
n. Admission packet did not disclose exact cost of obtaining a copy of residents medical records. Stated facility will charge a reasonable fee. Did not disclose what the reasonable fee was;
o. Resident's hand book at page 10 stated: "regulations prohibits any resident in the assisted living

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facility to remain bed ridden for longer than 14 days." Regulatory requirement for facility with standard license or LNS license is 7 days, not 14 days;
p. Regulatory reference was made to chapter 400 and not chapter 429 of Florida Statutes (F.S.) Chapter 429 F.S. has been in effect since 2006;

2. During an interview on at 2:30 p.m., the Administrator confirmed that the facility never had an ECC license, which would allow the time frame for a resident to be bedridden to be 14 days.

3. Record review revealed that the following information was excluded from facility's contract:
a. A list of the specific services, supplies, and accommodations to be provided by the facility to the resident, including limited nursing services that the resident elects to receive;
b. A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees , in writing, to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;
c. A provision stating whether the facility is affiliated with any religious organization and , if so, which organization and its relationship to the facility;
d. A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), Florida Administrative Code (F.A.C.), and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule;
e. The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule;
f. The facility's policies and procedures related to a properly executed DH Form 1896, ;
g. The document on record was titled as "lease agreement", not a contract, and referred to residents as "lessees" and the provider as "lessor";
h. Page 1 paragraph 4 used the following language: "Sunnyside Manor staff and in accordance with Florida statutes and regulations affecting the operation of Adult Congregate Living Facilities." The facility is not an Adult Congregate Living Facility, it is an Assisted Living Facility. The term Assisted Living Facility was not found in the contract;
9. Regulatory reference was made to chapter 400 and not chapter 429 of F.S. Chapter 429 F.S. has been in effect since 2006;
i. Page 3, under "lessee's ." 8.5. Indicated "to pay for telephone long distance services

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charges." Page 12 where all charges were listed, number 3 stated "Long distance telephone charges as billed by Sunnyside Properties." No specific rate was mentioned;
j. Page 3, under "lessee's ." 8.7. "To arrange and pay for any personal dry cleaning made available at prevailing rates." Page 12 where all charges listed did not include dry cleaning rates;
k. Page 3, under "lessee's ." 8.10. "Lessee is obligated to make all arrangements for their own health care, dental care and mental health care that is to be provided by third parties." No reference was made of facility's policies in regards of coordination of services. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided as indicated by 58A.50182(7) F.A.C.;
l. Page 4, paragraph 16 states the following "when the apartment is vacated for any reason, SUNNYSIDE MANOR shall have the right to remove and store all property from the apartment which has been re -let for occupancy. The lessee shall be liable for all cost of moving and storage." Agreement did not indicate the cost of moving and storage. Per regulatory requirements storage is not to exceed 20% of monthly fee;
m. Page 6, paragraph 24. Renewals. The following stated "Either party may terminate this Agreement by giving thirty (30) days notice in advance,unless medical condition preempts,where apply ten (10) days notice is required."
Regulatory requirement is that the facility is to provide at least 45 days notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care, or the resident engages in a pattern of conduct that is harmful or offensive to other residents . In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days notice of a non emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction as it is indicated in 58A-5.0182(6).

2. During an interview on at 2:45 p.m., the Admission Coordinator stated that the admission packet provided was utilized for all assisted living residents. The Admission Coordinator said no documents were missing from the packet, stating "that is the packet I use every time I have a new resident. That is what I give to all of them. No, there is nothing missing from that packet."

3. During an interview on at 1:00 p.m., the Administrator acknowledged that indeed the admission packet was incomplete.

Class III

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

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Based on medical record review, and interview, the facility failed to ensure that residents who have had a significant change had a new Agency for Health Care Administration (AHCA) Resident Health Assessment (AHCA Form 1823) completed, as needed, for a significant change for 1 (Resident #9) of 2 resident records reviewed.

The findings included:

1. Resident #9 was readmitted to the facility on after hospitalization and rehabilitation for . An AHCA Form 1823, dated , identified that the resident was a risk; was independent with eating, toileting, and transferring; required supervision with ambulation and dressing; and required assistance with bathing.

Review of the medical record progress notes revealed that the resident had 11 times between and . Five of the resulted in injury and 1 overnight stay in the hospital for (CAT) scans to rule out a head injury.

In addition, a progress note written by the Director of Nursing stated (in part) "Spoke with daughter, [resident name] is requiring more assist with mobility, using the wheelchair more. Becoming more of , may need to go to long term care if he continues to decline."

2. During an interview on at 12:00 p.m., the Director of Nursing agreed that Resident #9 needed a new Resident Health Assessment completed for a significant change in condition; and commented, "He again last night."

Class III

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

Based on medical record review, observation, and interview, the facility failed to provide adequate and appropriate supervision and assistance to prevent for 1 (Resident #9) of 2 residents reviewed for requiring assistance with activities of daily living.

The findings included:

1. Resident #9 was readmitted to the facility on after hospitalization and rehabilitation for . An Resident Health Assessment AHCA Form 1823, dated , identified that the

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resident was a risk; was independent with eating, , toileting and transferring; required supervision with ambulation and dressing; and required assistance with bathing.

Review of the medical record progress notes revealed that the resident had 11 times between and . Five of the resulted in injury and 1 resulted in an overnight stay in the hospital to rule out a head injury. These occurred at various times during the day and evening hours, without a specific pattern. The occurred primarily in the living of the resident's apartment during transfer, and 3 occurred in the transfer and incontinence.

In addition, between and , the resident experienced episodes of crying and . In addition to the (,) for , the physician odered the (,) to be increased from 5 mg (milligrams) twice a day to 10 mg three times a day for . There is no documented evidence that the resident was seen by a psychiatrist to evaluate the use of this medication or what effect it might be having on the resident's incontinence and/or . Both and have side effects that include and drowsiness.

Review of the service plan, for this resident, revealed that there had been no change in the plan interventions, since readmission on , to prevent the reoccurrence of . A call pendant was initiated upon readmission, but the resident had not used this device to call for assistance. The only use has been documented as calling for help after a /injury had occurred. There is no documented evidence that 2 hour resident checks, to provide care and assistance with transfer and/or toileting, had been implemented by the resident caregivers.

In addition, a progress note written by the Director of Nursing (DON) stated (in part) "Spoke with daughter, (resident) is requiring more assist with mobility, using the wheelchair more. Becoming more of , unaware of incontinence until outer clothing is wet, staff is checking more frequently reminding him to check his pads, may need to go to long term care if he continues to decline."

2. On at 10:30 a.m., Resident #9 was observed sitting in a wheelchair at an activity. At 11:45 a.m., he independently wheeled himself into his apartment and transferred himself independently into a reclining chair. After speaking to the surveyor, he was observed at 12:05 p.m. transferring independently to his wheelchair and wheeling himself to the apartment door. A Resident Caregiver came to the apartment at that time and stated she was taking the resident to the dining . She did not suggest or provide any toileting, assistance or incontinence check; and was observed pushing his wheelchair to the main dining .

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3. During an interview on at 12:30 p.m., the Director of Nursing confirmed that the resident had not been seen by a psychiatrist at the time or since the was increased on .

During an interview on at 2:00 p.m., the DON acknowledged that Resident #9 had 11 in the past 2 months without the development of an effective plan to prevent reoccurrence and a Resident Health Assessment that continued to identify the resident as independent with toileting and transfer. The DON was re-interviewed at 12:00 p.m. on , and agreed that Resident #9 needed a new Resident Health Assessment AHCA Form 1823 completed for a significant change in condition. The DON stated "He again last night."

Class II

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

Based on record review, and staff interview, the facility failed to provide adequate and appropriate health care, consistent with established and recognized standards within the community, for 1 (Resident #9) of 2 residents reviewed for requiring assistance with activities of daily living. The Facility failed to comply with residents' rights by excluding the facility's policies and procedures in the resident admission packet utilized prior to admission to the facility. Furthermore, the facility failed to follow regulatory requirements in reference to residents discharge, as it is required by 58A-5.0182(6) Florida Administrative Code (F.A.C.). This has the potential for future disagreements or misunderstanding between residents or resident representatives and the facility.

The findings included:

1. Resident #9 was readmitted to the facility on after hospitalization and rehabilitation for . An Resident Health Assessment AHCA Form 1823, dated , identified that the resident was a risk; was independent with eating, , toileting and transferring; required supervision with ambulation and dressing; and required assistance with bathing.

Review of the medical record progress notes revealed that the resident had 11 times between and . Five of the resulted in injury and 1 resulted in an overnight stay in the hospital to rule out a head injury. These occurred at various times during the day and evening hours, without a specific pattern. The occurred primarily in the living of the resident's apartment during transfer, and 3 occurred in the transfer and incontinence.

In addition, between and , the resident experienced episodes of crying and , In

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addition to the (,) for , the physician ordered the ( ) to be increased from 5 mg (milligrams) twice a day to 10 mg three times a day for . There is no documented evidence that the resident was seen by a psychiatrist to evaluate the use of this medication or what effect it might be having on the resident's incontinence and/or . Both and have side effects that include and drowsiness.

Review of the service plan, for this resident, revealed that there had been no change in the plan interventions, since readmission on , to prevent the reoccurrence of . A call pendant was initiated upon readmission, but the resident had not used this device to call for assistance. The only use has been documented as calling for help after a /injury had occurred. There is no documented evidence that 2 hour resident checks, to provide care and assistance with transfer and/or toileting, had been implemented by the resident caregivers.

In addition, a progress note written by the Director of Nursing (DON) stated (in part) "Spoke with daughter, (resident) is requiring more assist with mobility, using the wheelchair more. Becoming more of , unaware of incontinence until outer clothing is wet, staff is checking more frequently reminding him to check his pads, may need to go to long term care if he continues to decline."

On at 10:30 a.m., Resident #9 was observed sitting in a wheelchair at an activity. At 11:45 a.m., he independently wheeled himself into his apartment and transferred himself independently into a reclining chair. After speaking to the surveyor, he was observed at 12:05 p.m. transferring independently to his wheelchair and wheeling himself to the apartment door. A Resident Caregiver came to the apartment at that time and stated she was taking the resident to the dining . She did not suggest or provide any toileting, assistance or incontinence check; and was observed pushing his wheelchair to the main dining .

During an interview on at 12:30 p.m., the Director of Nursing confirmed that the resident had not been seen by a psychiatrist at the time or since the was increased on .

During an interview on at 2:00 p.m., the DON acknowledged that Resident #9 had 11 in the past 2 months without the development of an effective plan to prevent reoccurrence and a Resident Health Assessment that continued to identify the resident as independent with toileting and transfer. The DON was re-interviewed at 12:00 p.m. on , and agreed that Resident #9 needed a new Resident Health Assessment AHCA Form 1823 completed for a significant change in condition. The DON stated "He again last night."

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2. Record review of the facility's admission packet found that packet excluded the following policies and procedures:
a. and tobacco;
b. Medication storage;
c. Resident elopement;
d. Reporting resident , neglect, and , ;
e. Administrative and housekeeping schedules and requirements;
f. control, sanitation, and universal precautions;
g. The requirements for coordinating the delivery of services to residents by third party providers.

Review of the facility's contract found the following:
a. Page 6 Paragraph 24. Renewals. The following stated " Either party may terminate this Agreement by giving thirty (30) days notice in advance, unless medical condition preempts, where apply ten (10) days notice is required."
b. Chapter 429.28 Florida Statutes The regulatory requirement is that the facility is to provide at least 45 days notice of relocation or termination of residency from the facility. Unless for medical reasons, if the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days notice of a non emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction as it is indicated in 58A-5.0182(6).

The Resident Rights brochure on record utilized Regulatory reference to Chapter 400 and not Chapter 429 of the Florida Statutes (F.S.). Chapter 429 F.S. has been in effect since 2006.

During an interview on at 1:10 p.m., The Administrator acknowledged that facility's contract and admission packet were incomplete.

Class II

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review, and staff interview, the facility failed to ensure that 3 (Staff C, D, and E) of 5 staff obtained the required trainings.

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The findings included:

1. Record review for certified nursing assistant (CNA) Staff C found she was hired on . Further record review for CNA Staff C found an Employee In Service history log that documented the following trainings:
One hour of elopement training completed on . No documentation was attached indicating that a copy of the facility's resident elopement response policies and procedures was given to CNAStaff C. Furthermore, there was no verification that staff was able to demonstrate and understand, or saw evidence of competency in the implementation of the elopement response policies and procedures.

The log did not indicate who the instructor was. It also did not include certificates or copies of certificates for trainings provided.

There was also an unsigned pre-service plan that included 16 trainings, a tour of the building and review of personnel manual and compliance handbook and indicated the orientation was completed on from 8:30 a.m. to 1:30 p.m. The document did not include the name of instructor, with credentials and license, programs agenda, or certificates.

During an interview on at 2:00 p.m., the Administrator said that facility's staff developer was responsible for all trainings. She also said the staff developer was not CORE certified. The Administrator said she was unaware of the requirement.

2. Record review for certified nursing assistant (CNA) Staff D found she was hired . Further review for CNA Staff D found an Employee In Service history log indicating CNA Staff D completed 1 hour ALF training on . The log did not include certificates or copies of certificates for training provided.

There was also an Inservice Form, dated , showing 10 hours and 25 minutes of training on for 16 trainings, but no certificates were attached.

3. Record review for registered nurse (RN) Staff E found she was hired . Further review found an orientation ALF checklist dated 11/ . The orientation list included: disaster plan and evacuation plan, major incident and emergency procedures, resident rights, , neglect and , , and safe food handling practices. The checklist was signed by RN Staff E on and her supervisor on . The check list did not include hours of training. It also did not have attached certificates or

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copies of certificates for trainings provided with the title of the training program, the agenda, the trainer's credentials and license, or the location of training.

During an interview on at 10:30 a.m., the Director of Nursing said that caregiver Staff E's supervisor (person who signed the training log) was not CORE certified.

4. During an interview on at 1:10 p.m., the Administrator acknowledged that none of the caregiver staff reviewed had the required trainings.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on record review, and interview, the facility failed to ensure 3 (Staff C, D, and E) of 5 staff contained documentation of / trainings.

The findings included:

1. Record review revealed that Staff C was employed on as a certified nursing assistant (CNA). Further review found an certificate dated with no credit hours. The training was provided by Director of Human Resources, who was not CORE certified. Furthermore, there was an Inservice history log provided listing training completed on . The log did not include certificates or copies of certificates for trainings provided.

Record review revealed Staff D was employed on as a certified nursing assistant. Staff record review for CNA Staff D found an Inservice Form dated . The form included training. The trainer was not CORE certified. Furthermore, there was no certificate or copies of certificate for trainings provided.

Record review revealed Staff E was employed on as a registered nurse (RN). Staff record review for RN Staff E found an in service form dated 11/ . The form included training. The trainer was not CORE certified. Furthermore, there was no certificate or copies of certificate for trainings provided.

2. During an interview on at 1:10 p.m., the Administrator confirmed the lack of the appropriate training from a qualified trainer.

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Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review, and interview, the facility failed to obtain 1 hour ( ) training within 30 days of employment for 3 (Staff C, D, and E) of 5 staff sampled.

The findings included:

1. Record review for certified nursing assistant (CNA) Staff C found she was hired on . Further review for CNA Staff C found an Employee Inservice history log that documented training was completed on . The training was only for 25 minutes, not an hour as it is required. The training did not include the instructors name and credentials, signature, the agenda, or the training location.

2. Record review for certified nursing assistant (CNA) Staff D found she was hired . Further record review for CNA Staff D found an Inservice Form that documented training was completed on . The training was only for 25 minutes, not an hour as it is required. The training did not include the instructors name and license, the agenda, or the training location.

3. Record review for registered nurse (RN) Staff E found she was hired . Further record review for RN Staff D found an Inservice Form that documented training was completed on 11/ . The training was only for 25 minutes, not an hour as it is required. The training did not include the instructors name and license, the agenda, or the training location.

4. During an interview on at 1:10 p.m., the Administrator acknowledged that the training on file did not meet regulatory requirements.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review and staff interview, the facility failed to appropriately document required trainings for 3 (Staff C, D, and E) of 5 staff reviewed.

The findings included:

1. Record review for certified nursing assistant (CNA) Staff C found she was hired on . Record review for CNA Staff D found she was hired . Record review for registered nurse Staff E found

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she was hired . All 3 staff records showed only an orientation checklist. The staff records did not include certificates or copies of certificates for trainings provided with title of the training program, the agenda, the trainer's name, credentials, and license, or the location of trainings.

2. During an interview on at 1:10 p.m. the Administrator acknowledged the lack of complete documentation.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview, the facility failed to ensure a complete and accurate duplicate original contract was in each resident's file for 2 (Residents #6 and #9) of 2 resident records reviewed. The facility failed to ensure the contracts contained all required information. Failure to maintain contracts including addendums may lead to billing irregularities.

The findings included:

1. Record review reveled that the following information was excluded from Resident #6 and Resident #9's contract:

a. A list of the specific services, supplies, and accommodations to be provided by the facility to the resident, including limited nursing that the resident elects to receive;
b. A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;
c. A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility;
d. A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), Florida Administrative Code (F.A.C.), and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule;
e. The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes

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provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule;
f. The facility's policies and procedures related to a properly executed DH Form 1896, [illegible]
;
g. The document on record was titled as "lease agreement", not a contract and referred to residents as "lessees" and the provider as "lessor";
h. Page 1, paragraph 4 used the following language: "Sunnyside Manor staff and in accordance with Florida Statutes (F.S.) and regulations affecting the operation of Adult Congregate Living Facilities." Facility is not an Adult Congregate Living Facility, it is an Assisted Living Facility. Term was not found in the contract;
i. Regulatory reference was made to chapter 400 and not chapter 429 of F.S., Chapter 429 F.S. has been in effect since 2006;
j. Page 3. Under "lessee's [illegible]." 8.5. Indicated "to pay for telephone long distance services charges." Page 12 where all charges were listed, number 3 stated "Long distance telephone charges as billed by Sunnyside Properties." Not specific rate mentioned;
k. Page 3. Under "lessee's [illegible]." 8.7. "To arrange and pay for any personal dry cleaning made available at prevailing rates." Page 12 where all charges listed did not include dry cleaning rates;
l. Page 3. Under "lessee's [illegible]." 8.10. "Lessee is obligated to make all arrangements for their own health care, dental care and mental health care that is to be provided by third parties." No reference was made of the facility's policies in regards of coordination of services. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided, as indicated by 58A.50182(7) F.A.C.;
m. Page 4, paragraph 16 states the following "when the apartment is vacated for any reason, SUNNYSIDE MANOR shall have the right to remove and store all property from the apartment which has been re -let for occupancy. The lessee shall be liable for all cost of moving and storage." The agreement did not indicate the cost of moving and storage. Per regulatory requirements, storage is not to exceed 20% of monthly fee;
n. Page 6, paragraph 24. Renewals. The following stated "Either party may terminate this Agreement by giving thirty (30) days notice in advance,unless medical condition preempts,where apply ten (10) days notice is required."
The regulatory requirement is that the facility is to provide at least 45 days notice of relocation or termination of residency from the facility. Unless for medical reasons, if the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days notice of a non emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction as it is indicated in

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58A-5.0182(6).

2. During an interview on at 1:10 p.m., the Administrator acknowledged that the facility's contract was incomplete.

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0000 - Initial Comments

An unannounced biennial survey was conducted through at Sunnyside Manor, an assisted living facility (license #7952) in Sarasota, Florida.

The following is description of the deficiencies.

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review, and interview, the facility failed to ensure a complete admission packet was available for new admissions to the facility. Failure to provide a complete admission packet leads to a lack of necessary information and may lead to misunderstanding between the resident or their representative and the facility.

The findings included:

1. Record review of the facility's admission packet revealed that the following information was not included:
a. The facility's admission and continued residency criteria;
b. The daily, weekly or monthly charge for Limited Nursing services (LNS) and list of all services provided;
c. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any;
d. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any;
e. The facility's resident elopement response policies and procedures;
f. Admission and retention policy;
g. policy;
h. Medication storage policy;
i. Elopement policy;
j. Reporting , neglect, and policy;
k. Administration scheduled availability;
l. control, sanitation, and universal precaution policy;
m. Third party coordination policy (including coordination of communications);
n. Admission packet did not disclose exact cost of obtaining a copy of residents medical records. Stated facility will charge a reasonable fee. Did not disclose what the reasonable fee was;
o. Resident's hand book at page 10 stated: "regulations prohibits any resident in the assisted living

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facility to remain bed ridden for longer than 14 days." Regulatory requirement for facility with standard license or LNS license is 7 days, not 14 days;
p. Regulatory reference was made to chapter 400 and not chapter 429 of Florida Statutes (F.S.) Chapter 429 F.S. has been in effect since 2006;

2. During an interview on at 2:30 p.m., the Administrator confirmed that the facility never had an ECC license, which would allow the time frame for a resident to be bedridden to be 14 days.

3. Record review revealed that the following information was excluded from facility's contract:
a. A list of the specific services, supplies, and accommodations to be provided by the facility to the resident, including limited nursing services that the resident elects to receive;
b. A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees , in writing, to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;
c. A provision stating whether the facility is affiliated with any religious organization and , if so, which organization and its relationship to the facility;
d. A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), Florida Administrative Code (F.A.C.), and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule;
e. The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule;
f. The facility's policies and procedures related to a properly executed DH Form 1896, ;
g. The document on record was titled as "lease agreement", not a contract, and referred to residents as "lessees" and the provider as "lessor";
h. Page 1 paragraph 4 used the following language: "Sunnyside Manor staff and in accordance with Florida statutes and regulations affecting the operation of Adult Congregate Living Facilities." The facility is not an Adult Congregate Living Facility, it is an Assisted Living Facility. The term Assisted Living Facility was not found in the contract;
9. Regulatory reference was made to chapter 400 and not chapter 429 of F.S. Chapter 429 F.S. has been in effect since 2006;
i. Page 3, under "lessee's ." 8.5. Indicated "to pay for telephone long distance services

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charges." Page 12 where all charges were listed, number 3 stated "Long distance telephone charges as billed by Sunnyside Properties." No specific rate was mentioned;
j. Page 3, under "lessee's ." 8.7. "To arrange and pay for any personal dry cleaning made available at prevailing rates." Page 12 where all charges listed did not include dry cleaning rates;
k. Page 3, under "lessee's ." 8.10. "Lessee is obligated to make all arrangements for their own health care, dental care and mental health care that is to be provided by third parties." No reference was made of facility's policies in regards of coordination of services. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided as indicated by 58A.50182(7) F.A.C.;
l. Page 4, paragraph 16 states the following "when the apartment is vacated for any reason, SUNNYSIDE MANOR shall have the right to remove and store all property from the apartment which has been re -let for occupancy. The lessee shall be liable for all cost of moving and storage." Agreement did not indicate the cost of moving and storage. Per regulatory requirements storage is not to exceed 20% of monthly fee;
m. Page 6, paragraph 24. Renewals. The following stated "Either party may terminate this Agreement by giving thirty (30) days notice in advance,unless medical condition preempts,where apply ten (10) days notice is required."
Regulatory requirement is that the facility is to provide at least 45 days notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care, or the resident engages in a pattern of conduct that is harmful or offensive to other residents . In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days notice of a non emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction as it is indicated in 58A-5.0182(6).

2. During an interview on at 2:45 p.m., the Admission Coordinator stated that the admission packet provided was utilized for all assisted living residents. The Admission Coordinator said no documents were missing from the packet, stating "that is the packet I use every time I have a new resident. That is what I give to all of them. No, there is nothing missing from that packet."

3. During an interview on at 1:00 p.m., the Administrator acknowledged that indeed the admission packet was incomplete.

Class III

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

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Based on medical record review, and interview, the facility failed to ensure that residents who have had a significant change had a new Agency for Health Care Administration (AHCA) Resident Health Assessment (AHCA Form 1823) completed, as needed, for a significant change for 1 (Resident #9) of 2 resident records reviewed.

The findings included:

1. Resident #9 was readmitted to the facility on after hospitalization and rehabilitation for . An AHCA Form 1823, dated , identified that the resident was a risk; was independent with eating, toileting, and transferring; required supervision with ambulation and dressing; and required assistance with bathing.

Review of the medical record progress notes revealed that the resident had 11 times between and . Five of the resulted in injury and 1 overnight stay in the hospital for (CAT) scans to rule out a head injury.

In addition, a progress note written by the Director of Nursing stated (in part) "Spoke with daughter, [resident name] is requiring more assist with mobility, using the wheelchair more. Becoming more of , may need to go to long term care if he continues to decline."

2. During an interview on at 12:00 p.m., the Director of Nursing agreed that Resident #9 needed a new Resident Health Assessment completed for a significant change in condition; and commented, "He again last night."

Class III

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

Based on medical record review, observation, and interview, the facility failed to provide adequate and appropriate supervision and assistance to prevent for 1 (Resident #9) of 2 residents reviewed for requiring assistance with activities of daily living.

The findings included:

1. Resident #9 was readmitted to the facility on after hospitalization and rehabilitation for . An Resident Health Assessment AHCA Form 1823, dated , identified that the

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resident was a risk; was independent with eating, , toileting and transferring; required supervision with ambulation and dressing; and required assistance with bathing.

Review of the medical record progress notes revealed that the resident had 11 times between and . Five of the resulted in injury and 1 resulted in an overnight stay in the hospital to rule out a head injury. These occurred at various times during the day and evening hours, without a specific pattern. The occurred primarily in the living of the resident's apartment during transfer, and 3 occurred in the transfer and incontinence.

In addition, between and , the resident experienced episodes of crying and . In addition to the (,) for , the physician odered the ( ) to be increased from 5 mg (milligrams) twice a day to 10 mg three times a day for . There is no documented evidence that the resident was seen by a psychiatrist to evaluate the use of this medication or what effect it might be having on the resident's incontinence and/or . Both and have side effects that include and drowsiness.

Review of the service plan, for this resident, revealed that there had been no change in the plan interventions, since readmission on , to prevent the reoccurrence of . A call pendant was initiated upon readmission, but the resident had not used this device to call for assistance. The only use has been documented as calling for help after a /injury had occurred. There is no documented evidence that 2 hour resident checks, to provide care and assistance with transfer and/or toileting, had been implemented by the resident caregivers.

In addition, a progress note written by the Director of Nursing (DON) stated (in part) "Spoke with daughter, (resident) is requiring more assist with mobility, using the wheelchair more. Becoming more of , unaware of incontinence until outer clothing is wet, staff is checking more frequently reminding him to check his pads, may need to go to long term care if he continues to decline."

2. On at 10:30 a.m., Resident #9 was observed sitting in a wheelchair at an activity. At 11:45 a.m., he independently wheeled himself into his apartment and transferred himself independently into a reclining chair. After speaking to the surveyor, he was observed at 12:05 p.m. transferring independently to his wheelchair and wheeling himself to the apartment door. A Resident Caregiver came to the apartment at that time and stated she was taking the resident to the dining . She did not suggest or provide any toileting, assistance or incontinence check; and was observed pushing his wheelchair to the main dining .

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3. During an interview on at 12:30 p.m., the Director of Nursing confirmed that the resident had not been seen by a psychiatrist at the time or since the was increased on .

During an interview on at 2:00 p.m., the DON acknowledged that Resident #9 had 11 in the past 2 months without the development of an effective plan to prevent reoccurrence and a Resident Health Assessment that continued to identify the resident as independent with toileting and transfer. The DON was re-interviewed at 12:00 p.m. on , and agreed that Resident #9 needed a new Resident Health Assessment AHCA Form 1823 completed for a significant change in condition. The DON stated "He again last night."

Class II

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

Based on record review, and staff interview, the facility failed to provide adequate and appropriate health care, consistent with established and recognized standards within the community, for 1 (Resident #9) of 2 residents reviewed for requiring assistance with activities of daily living. The Facility failed to comply with residents' rights by excluding the facility's policies and procedures in the resident admission packet utilized prior to admission to the facility. Furthermore, the facility failed to follow regulatory requirements in reference to residents discharge, as it is required by 58A-5.0182(6) Florida Administrative Code (F.A.C.). This has the potential for future disagreements or misunderstanding between residents or resident representatives and the facility.

The findings included:

1. Resident #9 was readmitted to the facility on after hospitalization and rehabilitation for . An Resident Health Assessment AHCA Form 1823, dated , identified that the resident was a risk; was independent with eating, , toileting and transferring; required supervision with ambulation and dressing; and required assistance with bathing.

Review of the medical record progress notes revealed that the resident had 11 times between and . Five of the resulted in injury and 1 resulted in an overnight stay in the hospital to rule out a head injury. These occurred at various times during the day and evening hours, without a specific pattern. The occurred primarily in the living of the resident's apartment during transfer, and 3 occurred in the transfer and incontinence.

In addition, between and , the resident experienced episodes of crying and , In

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addition to the (,) for , the physician ordered the ( ) to be increased from 5 mg (milligrams) twice a day to 10 mg three times a day for . There is no documented evidence that the resident was seen by a psychiatrist to evaluate the use of this medication or what effect it might be having on the resident's incontinence and/or . Both and have side effects that include and drowsiness.

Review of the service plan, for this resident, revealed that there had been no change in the plan interventions, since readmission on , to prevent the reoccurrence of . A call pendant was initiated upon readmission, but the resident had not used this device to call for assistance. The only use has been documented as calling for help after a /injury had occurred. There is no documented evidence that 2 hour resident checks, to provide care and assistance with transfer and/or toileting, had been implemented by the resident caregivers.

In addition, a progress note written by the Director of Nursing (DON) stated (in part) "Spoke with daughter, (resident) is requiring more assist with mobility, using the wheelchair more. Becoming more of , unaware of incontinence until outer clothing is wet, staff is checking more frequently reminding him to check his pads, may need to go to long term care if he continues to decline."

On at 10:30 a.m., Resident #9 was observed sitting in a wheelchair at an activity. At 11:45 a.m., he independently wheeled himself into his apartment and transferred himself independently into a reclining chair. After speaking to the surveyor, he was observed at 12:05 p.m. transferring independently to his wheelchair and wheeling himself to the apartment door. A Resident Caregiver came to the apartment at that time and stated she was taking the resident to the dining . She did not suggest or provide any toileting, assistance or incontinence check; and was observed pushing his wheelchair to the main dining .

During an interview on at 12:30 p.m., the Director of Nursing confirmed that the resident had not been seen by a psychiatrist at the time or since the was increased on .

During an interview on at 2:00 p.m., the DON acknowledged that Resident #9 had 11 in the past 2 months without the development of an effective plan to prevent reoccurrence and a Resident Health Assessment that continued to identify the resident as independent with toileting and transfer. The DON was re-interviewed at 12:00 p.m. on , and agreed that Resident #9 needed a new Resident Health Assessment AHCA Form 1823 completed for a significant change in condition. The DON stated "He again last night."

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2. Record review of the facility's admission packet found that packet excluded the following policies and procedures:
a. and tobacco;
b. Medication storage;
c. Resident elopement;
d. Reporting resident , neglect, and , ;
e. Administrative and housekeeping schedules and requirements;
f. control, sanitation, and universal precautions;
g. The requirements for coordinating the delivery of services to residents by third party providers.

Review of the facility's contract found the following:
a. Page 6 Paragraph 24. Renewals. The following stated " Either party may terminate this Agreement by giving thirty (30) days notice in advance, unless medical condition preempts, where apply ten (10) days notice is required."
b. Chapter 429.28 Florida Statutes The regulatory requirement is that the facility is to provide at least 45 days notice of relocation or termination of residency from the facility. Unless for medical reasons, if the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days notice of a non emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction as it is indicated in 58A-5.0182(6).

The Resident Rights brochure on record utilized Regulatory reference to Chapter 400 and not Chapter 429 of the Florida Statutes (F.S.). Chapter 429 F.S. has been in effect since 2006.

During an interview on at 1:10 p.m., The Administrator acknowledged that facility's contract and admission packet were incomplete.

Class II

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review, and staff interview, the facility failed to ensure that 1 (Staff D) of 5 staff obtained the required trainings timely.

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The findings included:

Record review for certified nursing assistant (CNA) Staff D found she was hired . Further review for CNA Staff D found an Employee In Service history log indicating CNA Staff D completed 1 hour ALF training on .

During an interview on at 2:00 p.m., the Administrator said that facility's staff developer was responsible for all trainings.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review, and interview, the facility failed to obtain 1 hour ( ) training within 30 days of employment for 3 (Staff C, D, and E) of 5 staff sampled.

The findings included:

1. Record review for certified nursing assistant (CNA) Staff C found she was hired on . Further review for CNA Staff C found an Employee In Service history log that documented training was completed on . The training was only for 25 minutes, not an hour as it is required.

2. Record review for certified nursing assistant (CNA) Staff D found she was hired . Further record review for CNA Staff D found an In Service Form that documented training was completed on . The training was only for 25 minutes, not an hour as it is required.

3. Record review for registered nurse (RN) Staff E found she was hired . Further record review for RN Staff D found an In Service Form that documented training was completed on 11/ . The training was only for 25 minutes, not an hour as it is required.

4. During an interview on at 1:10 p.m., the Administrator acknowledged that the training on file did not meet regulatory requirements.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

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Based on record review and staff interview, the facility failed to appropriately document required trainings for 3 (Staff C, D, and E) of 5 staff reviewed.

The findings included:

Record review revealed that Staff C was employed on . . . . as a certified nursing assistant (CNA). Further review found an certificate dated with no credit hours. There was an In Service history log provided listing training completed on . . . . . The log did not include certificates or copies of certificates for trainings provided.

Record review revealed Staff D was employed on as a certified nursing assistant. Staff record review for CNA Staff D found an In Service Form dated . . . . . The form included training. There was no certificate or copies of certificate for trainings provided.

Record review revealed Staff E was employed on as a registered nurse (RN). Staff record review for RN Staff E found an In Service form dated 11/ . . . The form included training.

All 3 staff records showed only an orientation checklist. The staff records did not include certificates or copies of certificates for trainings provided with title of the training program, the agenda, the trainer's name, and license, or the location of trainings.

During an interview on . . . . at 1:10 p.m. the Administrator acknowledged the lack of complete documentation.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview, the facility failed to ensure a complete and accurate duplicate original contract was in each resident's file for 2 (Residents #6 and #9) of 2 resident records reviewed. The facility failed to ensure the contracts contained all required information. Failure to maintain contracts including addendums may lead to billing irregularities.

The findings included:

1. Record review reveled that the following information was excluded from Resident #6 and Resident #9's contract:

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a. A list of the specific services, supplies, and accommodations to be provided by the facility to the resident, including limited nursing that the resident elects to receive;
b. A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or , facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;
c. A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility;
d. A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), Florida Administrative Code (F.A.C.), and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule;
e. The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule;
f. The facility's policies and procedures related to a properly executed DH Form 1896, ;
g. The document on record was titled as "lease agreement", not a contract and referred to residents as "lessees" and the provider as "lessor";
h. Page 1, paragraph 4 used the following language: "Sunnyside Manor staff and in accordance with Florida Statutes (F.S.) and regulations affecting the operation of Adult Congregate Living Facilities." Facility is not an Adult Congregate Living Facility, it is an Assisted Living Facility. Term was not found in the contract;
i. Regulatory reference was made to chapter 400 and not chapter 429 of F.S., Chapter 429 F.S. has been in effect since 2006;
j. Page 3. Under "lessee's ." 8.5. Indicated "to pay for telephone long distance services charges." Page 12 where all charges were listed, number 3 stated "Long distance telephone charges as billed by Sunnyside Properties." Not specific rate mentioned;
k. Page 3. Under "lessee's ." 8.7. "To arrange and pay for any personal dry cleaning made available at prevailing rates." Page 12 where all charges listed did not include dry cleaning rates;
l. Page 3. Under "lessee's ." 8.10. "Lessee is obligated to make all arrangements for their own health care, dental care and mental health care that is to be provided by third parties." No reference was made of the facility's policies in regards of coordination of services. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922273	**04/12/2018**
NAME OF PROVIDER OR SUPPLIER **SUNNYSIDE MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **5201 BAHIA VISTA STREET** **SARASOTA, FL 34232**	

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

being provided, as indicated by 58A.50182(7) F.A.C.;
m. Page 4, paragraph 16 states the following "when the apartment is vacated for any reason, SUNNYSIDE MANOR shall have the right to remove and store all property from the apartment which has been re -let for occupancy. The lessee shall be liable for all cost of moving and storage." The agreement did not indicate the cost of moving and storage. Per regulatory requirements, storage is not to exceed 20% of monthly fee;
n. Page 6, paragraph 24. Renewals. The following stated "Either party may terminate this Agreement by giving thirty (30) days notice in advance,unless medical condition preempts,where apply ten (10) days notice is required."
The regulatory requirement is that the facility is to provide at least 45 days notice of relocation or termination of residency from the facility. Unless for medical reasons, if the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days notice of a non emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction as it is indicated in 58A-5.0182(6).

2. During an interview on [illegible] at 1:10 p.m., the Administrator acknowledged that the facility's contract was incomplete.

Class III