

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910054</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/07/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**SUN TOWERS RETIREMENT COMMUNITY**

**101 TRINITY LAKES DRIVE  
SUN CITY CENTER, FL 33573**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>An Extended Congregate Care (ECC) Monitoring was conducted at Sun Towers Retirement Community on . Deficiencies were identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | A 000               |                                                                                                                          |                          |
| A 162<br>SS=D            | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. . . . ,<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of other health insurance . . . . ,<br>8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and,<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.<br>(c) Any orders for medications, nursing services, therapeutic diets, . . . . ., or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.<br>(f) A record that is initiated on admission. | A 162               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910054</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/07/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUN TOWERS RETIREMENT COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>101 TRINITY LAKES DRIVE<br/>SUN CITY CENTER, FL 33573</b>                    |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 162                                                                      | <p>Continued From page 1</p> <p>Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually.</p> <p>(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.</p> <p>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.</p> <p>(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.</p> <p>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.</p> <p>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S.</p> <p>(l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____ (_____), CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a>. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has</p> | A 162                                                                          |                                                                                                                          |  |                                                        |

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| A 162                    | <p>Continued From page 2</p> <p>made a good faith effort to obtain the required documentation from the Department of Children and Families.</p> <p>(m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.</p> <p>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.</p> <p>(o) The resident's _____, DH Form 1896, if applicable.</p> <p>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility:</p> <ol style="list-style-type: none"> <li>1. A log listing the names of residents participating in this arrangement,</li> <li>2. The resident demographic data required in this paragraph,</li> <li>3. The health assessment described in rule 59A-36.006, F.A.C.,</li> <li>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,</li> <li>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.</li> </ol> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon</p> | A 162               |                                                                                                                          |                          |

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| A 162                    | <p>Continued From page 3</p> <p>departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to obtain an interdisciplinary care plan that described the care and services provided by Hospice and those provided by the Facility and authorization or consent for Hospice services for two Residents (#16 and #17) of two sampled residents admitted to Hospice services.</p> <p>Findings Included:</p> <p>During an interview with Resident #17, conducted on _____ at 04:56pm, Resident #17 stated that no one from the Facility or Hospice discussed with him or described the care and services provided by Hospice and those that were provided by the Facility.</p> <p>During an interview with Resident #16, conducted on _____ at 05:03pm, Resident #16 stated that no one from the Facility or Hospice discussed with him or described the care and services provided by Hospice and those that were provided by the Facility.</p> <p>A record review for Resident #16, conducted on _____, revealed that Resident #16 did not have an interdisciplinary care plan that described the care and services provided by Hospice and those provided by the Facility in the resident's record.</p> | A 162               |                                                                                                                          |                          |

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| A 162                    | <p>Continued From page 4</p> <p>A record review for Resident #17, conducted on _____ revealed that Resident #17 had an interdisciplinary care plan that was not signed in agreement by Hospice, the Facility, or Resident #17 and/or responsible party. Resident #17 did not have an authorization or consent form signed agreeing to Hospice services in the resident's record.</p> <p>During an interview with the Regional Director of Clinical Services (Staff H), conducted on _____ at 06:23pm, Staff H agreed that Resident #16 did not have an interdisciplinary care plan that described the care and services provided by Hospice and those provided by the Facility in the resident's record. Staff H agreed that Resident #17 did not have an interdisciplinary care plan that was signed in agreement by Hospice, the Facility, or Resident #17 and/or responsible party and that Resident #17 did not have an authorization or consent form signed agreeing to Hospice services in the resident's record.</p> <p>Class III</p> | A 162               |                                                                                                                          |                          |