

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966301	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/02/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUN COAST RETREAT

**8151 TREELET COURT
NEW PORT RICHEY, FL 34653**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A biennial survey with generator monitoring was conducted at Sun Coast Retreat on 11/02/2022. Deficiencies were identified at the time of the survey.	A 000		
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, _____, and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by	A 031		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER SUN COAST RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 8151 TREELET COURT NEW PORT RICHEY, FL 34653			
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A 031	Continued From page 1 the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to perform care coordination that included documented communication about the resident's condition and response to treatment or services,	A 031			

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A 031	Continued From page 2 or obtain a physician order for services for One (Resident #2) of one sampled. Findings Included: In an interview with Resident #2 conducted on at 10:39am, she stated she had a boil on her and that a care nurse was coming in to care for it. On at 1:00 p.m. an interview was conducted with the Resident Care Coordinator; she reviewed Resident #2's file and confirmed the resident was receiving care for a boil on her that the care nurses was providing treatment. An attempted record review of the facility's policy and procedure for third party services conducted on revealed there was no policy in place. In an interview with the home health agency registered nurse conducted on at 1:56 p.m., she confirmed that she provided care to Resident #2 and she last provided care on On a record review of Resident#2 file revealed no documentation of an order for treatment for care or any notes of treatment since Class III	A 031		

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A 052	Continued From page 3	A 052		
A 052 SS=D	429.256(. . .); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an . . . syringe that is prefilled with the proper dosage by a pharmacist and an . . . that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying . . . medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a . . . , including removing the cap of a , opening the unit	A 052		

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A 052	Continued From page 4 dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (4) Assistance with self-administration of medication does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.	A 052		

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A 052	Continued From page 5 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self-administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,	A 052			

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A 052	Continued From page 6 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the Facility failed to ensure proper assistance with self-administration of medications for one (Resident #2) of four sampled residents that required assistance with self-administration of medication. Findings Included: In an observation conducted at 10:39am on Resident #2 was observed with a paper souffle cup full of 11 pills on the table next to her chair.	A 052		

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A 052	Continued From page 7 In an interview conducted with Resident #2 at 10:39am on she stated "I cannot take that many pills on an empty They brought them about 8:20am or 8:30am. I have memory problems and get busy doing something else and totally forget." In an observation in Resident #2's room conducted at 11:15am on the cup of pills was still sitting on the table in the resident room. In an interview with Resident #2 conducted at 11:15am on she said her memory is bad and she kept forgetting to take the pills. In a review of the Medication Observation Record for Resident #2 conducted on there were 10 medications ordered for 8:30am and 1 medication ordered for 06:30am. In an interview with the Assistant Administrator conducted at 11:35pm on she stated the policy was to watch the residents take their medications, and she would need to check with the employee giving out medications who had already left. Photographic Evidence Obtained. Class III	A 052			
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep	A 054			

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A 054	Continued From page 8 either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the Facility failed to administer medications as documented on the Medication Observation Records (MORs) for one (Resident #2) of one sampled residents. Findings Included: In a record review of the Medication	A 054			

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A 054	Continued From page 9 Observation Record for Resident #2 conducted on there were ten medications ordered for 8:30am, and one medication ordered for 06:30am, all signed off as given by Staff B. In an observation conducted at 10:39am on Resident #2 was observed with a paper souffle cup full of eleven pills on the table next to her chair. In an interview conducted with Resident #2 at 10:39am on she stated "I cannot take that many pills on an empty . They brought them about 8:20am or 8:30am. I have memory problems and get busy doing something else and totally forget." In an interview with the Administrator conducted on at 12:34pm he stated the staff should log the medications as given after the residents take them. Photographic Evidence Obtained. Class III	A 054		