Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966301	A. BUILDING: _____ B. WING _____	C 05/01/2024

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 complaint investigation (complaint number: 202400005580) and a generator monitoring were conducted at Suncoast Retreat on . Deficiencies were identified at the time of survey.	A 000		
A 052 SS=G	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.	A 052		

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A 052	Continued From page 1 (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 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.	A 052		

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A 052	Continued From page 2 (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. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] 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	A 052		

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A 052	Continued From page 3 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, 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, record review, and interview, the facility failed to ensure proper assistance with self-administration of medications which resulted in the hospitalization of one Resident (#1) of one sampled resident that received a medication overdose by the facility. Furthermore, the facility failed to develop and implement a corrective action plan for medication	A 052		

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A 052	Continued From page 4 error prevention which placed 76 of 76 residents at risk of harm or injury from a medication error. Findings Included: During an interview with a local hospital Representative, conducted on . . . . . at 08:59am, the Representative stated that Resident #1 was admitted to the emergency department on the morning of . Resident #1 received three doses of Narcan in the emergency department for receiving a medication overdose when the facility staff gave Resident #1 medications that belonged to Resident #2. Resident #1 had to be admitted to the hospital due to the medication error effects of . A review of Narcan, conducted on , revealed that the medical use for Narcan was for the emergency treatment of known or suspected . . . . overdose found at https://www.drugs.com/narcan.html A review of an in-house incident report, conducted on . . . . . , revealed that the in-house incident report dated at 05:45am, Resident #1 was sent to a local hospital regarding Staff B giving the resident medications that belonged to Resident #2. Staff B noted on the incident report that the medication error occurred because when the unlicensed Medication Technician took Resident #2's medications to Resident #2 and the resident was in the bathroom, Staff B left from Resident #2's room and placed the resident's medications on the medication cart. Staff B noted that she remembered that Resident #1 had just returned from the hospital the day before and went to give Resident #1's his medication when the employee was distracted by an unidentified resident yelling	A 052		

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A 052	Continued From page 5 for help. Staff B placed Resident #1's medications on the medication cart and assisted the unidentified resident and returned to assisting Resident #2 with his meds. Staff B noted that she picked up the medications and gave the medications to Resident #2 and when she returned to assisting Resident #1 with her medications, the employee realized that she had given Resident #1 medications that belonged to Resident #2. A supervisor review by Staff C of the incident report noted that Staff B was to retake the medication training and the employee was placed on observation for three months. A record review for Resident #1, conducted on , revealed that Resident #1 was admitted to the facility on . According to Resident #1's health assessment form dated , the resident had diagnoses of , and , was alert and oriented times three, and required the use of a walker for ambulation. Resident #1 had a in place and was independent with all activities of daily living. Resident #1 required assistance with self-administration of medications. A hospital visit report dated conducted on , noted that Resident #1 had a hospital visit diagnosis of "medication OVERDOSE" and reason: "overdose by facility". Resident #1 recovered from the medication overdose and was discharged to the facility on with no changes to the resident's medications. A medication observation record review for Resident #1, conducted on , Resident #1's 06:00am medications were documented as	A 052		

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A 052	Continued From page 6 given to Resident #1 by Staff B on [redacted] at 05:53am which included [redacted] 5mg, [redacted] 81mg, [redacted] 300mg, Cranberry 250mg, DOK 100mg, [redacted] 40mg, Ferosol 325mg, [redacted] /Salmeter [redacted] 1mg, [redacted] 50mg, [redacted] 20mg, [redacted] 25mg, [redacted] 1mg, [redacted] 100mg, and [redacted] 2mg. There was no evidence on Resident #1's medication observation records that the resident medications were held on [redacted] at 06:00am after receiving Resident #2's medications in error. A record review for Resident #2, conducted on [redacted], revealed that Resident #2 was admitted on [redacted]. According to Resident #2's health assessment form dated [redacted], Resident #2 had diagnoses of [redacted], and [redacted]. Resident #2 required assistance with self-administration of medications. A medication observation record review for Resident #2, conducted on [redacted], revealed that Resident #2's 06:00am medications were documented by Staff B to Resident #2 on [redacted] at 05:53am which included [redacted] 81mg, [redacted] 90mg, [redacted] 1mg, 24mg-26mg, [redacted] 10mg, [redacted] 600mg, [redacted] 500mg, [redacted] 25mg, [redacted] 15mg, [redacted] 30mg, and [redacted] 100mg. Resident #2's [redacted] had no documentation that the medication was given to the resident on [redacted] at 07:00pm. Due to missed documentation of Resident #2's [redacted] 30mg there was a discrepancy with the [redacted] count. The [redacted] count discrepancy went unnoticed by unlicensed Medication Technicians during changes in shifts on [redacted] at 11:00pm, [redacted] at 07:00am, [redacted] at	A 052		

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A 052	Continued From page 7 03:00pm, and [redacted] at 11:00pm. The discrepancy was found on [redacted] after Resident #1 received Resident #2's medications in error. During an interview with Staff A, conducted on [redacted] at 12:45pm, Staff A agreed that there appeared to be a discrepancy with the count for Resident #2's [redacted] 30mg that went unnoticed during four shift changes. An employee record review for Staff B, conducted on [redacted], revealed that there was no evidence that Staff B received additional training regarding medication errors or re-training for assistance with self-administration of medications since the employee provided medications to Resident #1 that belonged to Resident #2 on [redacted]. There was a disciplinary action in Staff B's employee record that noted that the action was a written and final warning and on [redacted] at 05:45am Staff B accidentally gave Resident #1 medications that belonged to Resident #2. The form noted that the error should never have happened and based on the investigation, Staff B pre-staged medications before passing the medications into cups and then passing or assisting the residents with their meds. Staff B was required to retake the medications training class. A review of the staffing schedule, conducted on [redacted], revealed that Staff B worked as an unlicensed Medication Technician on the 11:00pm through 06:00am shift on [redacted], and [redacted]. Staff B worked as an unlicensed Medication Technician on the 06:00pm through 06:00am shift on [redacted]. Staff had [redacted] and [redacted] off duty as these were the employees' normal days off.	A 052		

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A 052	Continued From page 8 There was no evidence Staff B received re-training for assistance with self-administration of medications as outlined in her writeup prior to resuming passing medications to residents. During an interview with Resident #1, conducted on . . . . . at 12:30pm, Resident #1 stated that he was not sure how he received the wrong medications but after prompting, Resident #1 stated that he did remember the but did not go into details. During an interview with Staff C (a Medication Technician Supervisor), conducted on at 12:27pm, Staff C stated that Staff B had notified her on that she had accidentally gave Resident #1 medications that belonged to Resident #2 due to a from another resident needing help and grabbed the wrong medications off the medication cart and gave them to Resident #1. Staff C stated that she quickly got off the telephone with the Supervisor B. Staff C then telephoned the Supervisor and Staff D separately and told the employees that when they got to the facility, Resident #1 needed to go to the hospital because of a medication error. Staff C stated that her first thought was to telephone the Supervisor because the employee was over all of the facility employees. Staff C was unable to explain the reason that she did not tell staff that were working at the facility at the time of the medication error to send Resident #1 to the hospital. During an interview with the Assistant Administrator, conducted on at 10:15am, the Assistant Administrator stated that on at 05:45am, Staff B had Resident #2's medications ready to pass to the resident but Resident #2 was in the bathroom. The Assistant	A 052		

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A 052	Continued From page 9 Administrator stated that Staff B set Resident #2's medication aside and then heard another (unidentified) resident call for help. The Assistant Administrator stated after checking on the unidentified resident, Staff B went ... to passing medications and picked up Resident #2's medications and to the medications to Resident #1. During an interview with the Assistant Administrator and the Administrator, conducted on at 01:30pm, the Assistant Administrator and the Administrator stated Staff B had received no re-training for assistance with self-administration of medications. The Assistant Administrator and the Administrator stated that Staff B had not received training regarding medications errors. The Assistant Administrator and the Administrator agreed that if unlicensed Medication Technicians get distracted while passing medications they should start the assistance process from the beginning and not pick up where they left off. The Assistant Administrator and the Administrator stated that none of the unlicensed Medication Technician that passed medications in the facility had received training regarding medication errors since Resident #1's medication overdose by Staff B on ... . Class II	A 052		