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
	AL11969485	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HARBOR	370 BLARNEY ST PORT CHARLOTTE, FL 33954

(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 An unannounced relicensure, emergency power plan monitoring, health facility reporting system, and visitation form survey was conducted on at Sunshine Harbor, an assisted living facility in Port Charlotte, Florida. The following is a description of the deficiencies:	A 000		
A 052 SS=E	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 .	A 052		

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A 052	Continued From page 1 (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 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	A 052		

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A 052	Continued From page 2 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. 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.	A 052		

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A 052	Continued From page 3 (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, 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, and interview, the facility failed to ensure staff performed hygiene according to policy for 3 (Resident #1, #2, and #4) out of 3 residents observed, and failed to ensure staff correctly assisted with an oral	A 052		

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A 052	Continued From page 4 dosage to 1 (Resident #4) out of 3 residents observed when assisting with the self-administration of medication. The findings included: Facility policy and procedure titled "Med Pass Inservice" indicated: 1. Check Resident's Chart 3. Wash 4. Take Labeled Medications to Resident's . Wash and put Gloves on 8. Make sure Resident swallows without complications 10. Sign MOR Book, meds given, Take Gloves off. Wash . **Photograph on File** On at 8:55 a.m., during a medication pass, Medication Technician (MT) Staff B was observed to provide 25 mg ( ), 2 mg ( ), 20 mg ( ), 20 meq (supplement), 50 mg (supplement), 1 mg (fluid retention), 30 mg ( ), C 1000 mg (supplement), and 50 mg ( ) to Resident #1. MT Staff B was not observed to wash or perform hygiene during the assistance with self-administration of medication. On at 9:00 a.m., during a medication pass, MT Staff B was observed to provide 20 mg ( ), 25 mg ( ), Farziga 10 mg ( ), 81 mg (maintenance), 25 mg ( ), Mirabegron 50 mg	A 052		

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A 052	Continued From page 5 (overactive), 60 mg ( ), , 30 mg ( ), , 300 mg ( ), D3 25 mcg (supplement), 80 mg ( ), , 5 mg ( ), , 75 mg (clots), 40 mg (high ,), and , 25 mg (,) to Resident #4. MT Staff B mixed the medications in vanilla pudding on a spoon and directly placed the spoon in the of Resident #4. MT Staff B was not observed to wash or perform hygiene during the assistance with self-administration of medication. On at 10:25 a.m., during a medication pass, MT Staff B was observed to provide 10 mg ( ), , 10 mg ( ), Fish Oil 1000 mg (supplement), 500 mg (supplement), , 81 mg (maintenance), 100 mg (supplement), B 100 mg (supplement), and , 325 mg (, relief) to Resident #2. . MT Staff B was not observed to wash or perform hygiene during the assistance with self-administration of medication. On , at 1:22 p.m., during an interview, MT Staff B said that she was scared and didn't wash her during the medication pass. She acknowledged that it was against facility policy and not what she was trained to do. On , at 1:33 p.m., during an interview, the Administrator acknowledged that it was against facility policy to fail to perform hygiene during assistance with self-administration of medication. When asked if Medication Technicians were to spoon feed medications to residents, she stated "No, they are not, they are not nurses."	A 052		

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A 052	Continued From page 6 Class III .	A 052		
A 054 SS=E	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 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.	A 054		

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A 054	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to immediately update the Medication Observation Record each time a medication is offered or administered for 3 (Resident #1, 2, and #4) out of 3 residents observed. The findings included: On at 8:55 a.m., during a medication pass, Medication Technician (MT) Staff B was observed to provide , , 25 mg (,), , 2 mg ( ), , 20 mg (, ,), 20 meq (, supplement), 50 mg (supplement), 1 mg (fluid retention), , 30 mg ( ), C 1000 mg (supplement), and 50 mg (,) to Resident #1. MT Staff B was not observed to document in the Medication Observation Record (MOR) that the medication was given. On at 9:00 a.m., during a medication pass, MT Staff B was observed to provide 20 mg (,), 25 mg (,), Farziga 10 mg ( ), , 81 mg (maintenance), , , 25 mg (,), Mirabegron 50 mg (overactive), 60 mg ( ), , 30 mg ( ), , 300 mg (,), D3 25 mcg (supplement), 80 mg ( ), , 5 mg ( ), , , 75 mg (clots), , 40 mg (high ,), and , 25 mg (,) to Resident #4. MT Staff B was not observed to document in the MOR that the medication was given.	A 054		

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A 054	Continued From page 8 On at 10:25 a.m., during a medication pass, MT Staff B was observed to provide 10 mg ( ), , 10 mg ( ), Fish Oil 1000 mg (supplement), 500 mg (supplement), , 81 mg (maintenance), 100 mg (supplement), B 100 mg (supplement), and , 325 mg (, relief) to Resident #2. MT Staff B was not observed to document in the MOR that the medication was given. On , during review of the Medication Observation Record, there was no documentation of medications being offered to Residents #1, #2, and #4 on . On at 12:38 p.m., MT Staff B was observed in the office looking for the Medication Observation Record (MOR). MT Staff B said that she was looking for the MOR to document the medications from the morning and lunch. On at 1:22 p.m., during an interview, MT Staff B stated that "She was overwhelmed and made a mistake" when asked why she didn't document on the MOR immediately. She acknowledged that it was against policy. On at 1:33 p.m., during an interview, the Administrator said that the policy is to have the MT take the MOR with them during medication pass, and document at the time the medications are offered. She acknowledged that documenting after the Medication Pass was against policy. Class III .	A 054		

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A 078	Continued From page 9	A 078		
A 078 SS=E	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their	A 078		

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A 078	Continued From page 10 responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility , to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that staff had evidence of a negative examination documented on an annual basis for 1 (Staff C) out of 3 staff records reviewed. The findings included: On , a record review of Medication Technician (MT) Staff C revealed a hire date of . Further review revealed a report of a negative Screening on . No	A 078		

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A 078	Continued From page 11 documentation of a negative examination for 2024 or 2025 was located in her file. ** Photograph on File** On at 1:33 p.m., during an interview, the Administrator and the Owner said they asked MT Staff C to go to the clinic to get the screening but were unsure if she had it done. The Owner and the Administrator acknowledged that MT Staff C did not have the annual negative documentation in her file. Class III .	A 078		
A 162 SS=E	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 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, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care	A 162		

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A 162	Continued From page 12 practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (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. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ˘ record that is initiated on admission. 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. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ˘ not be taken. (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. (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. (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. (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	A 162		

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A 162	Continued From page 13 statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (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. (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: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (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. (o) The resident's , DH Form 1896, if applicable. (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 a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be	A 162		

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SUNSHINE HARBOR	370 BLARNEY ST PORT CHARLOTTE, FL 33954

(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 162	Continued From page 14 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 departure from the facility. (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. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure residents receiving assistance with the activities of daily living have their weight recorded semi-annually for 1 (Resident #3) out of 2 records reviewed. The findings included: On 5/14/25, a record review for Resident #3 revealed an admission date of 6/14/24. Further review revealed a documented weight of 193 lbs. on 6/14/24 on the facility weight log. No additional weights for Resident #3 were documented on the weight log. **Photograph on File** On 5/14/25 at 12:10 p.m., during an interview, the Administrator said that Resident #3 should have more weights documented in his file and said that she could not find any additional documentation in his file. The Administrator said that MT Staff B weighed Resident #3 twice since admission but failed to write it down. The Administrator acknowledged the lack of documentation in the resident record.	A 162		

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
	AL11969485	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HARBOR	370 BLARNEY ST PORT CHARLOTTE, FL 33954

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A 162	Continued From page 15 Class III .	A 162		