STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942977	09/20/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Royal Sun Park	312 E 124 Ave Tampa, FL 33612	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2013009929, was conducted on .

The Royal Sun Park, assisted living facility, had deficiencies at the time of the visit.

0007-Admissions - Criteria 58A-5.0181(1) FAC

Based upon record review , the facility did not ensure that a licensed nurse was available to administer medications as ordered by the health care provider for 1 (#1) of 3 residents.

Findings include:

A review on of the resident record for resident #1, admitted on revealed the 1823 completed by the health care provider & dated ordered the resident to require the administration of medications.

The facility does not employ the services of a licensed nurse to administer medications. The facility only employs unlicensed staff who are trained to assist residents with self-administered medications.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based upon observation and staff interview, the facility failed to ensure the care and services provided met the needs of all 29 residents in the facility.

Findings include:

1. During staff interview, staff B expressed concern (10:20 am) that residents could not be adequately supervised with the current staffing levels-adding the following information;
Resident #3 makes inappropriate comments to female staff & residents and will grope them. Another resident (#4) is very physically aggressive and will use his fists to strike others (staff & residents). Another staff (C) confirmed this during interview at 10:30am.
Staff stated they were concerned about being able to protect other residents from being hurt. Staff also said

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that it takes 3 to 4 staff to provide hygiene care to 2 of the residents (#3 & #4). The staff also mentioned resident #2 would yell in staffs face. There was an activity director on site but during interview she confirmed she did not provide any direct care.

At about 11:00am when the surveyor went to observed resident #3, the resident could not be found either in the common area or his (#111). When staff were asked where this resident was, staff A stated the resident was usually found in other residents , either in # or #122. Resident #3 was found lying in another residents bed in (122- located on a separate hallway).

During interview with resident #3 at 11:30am when asked why he was in another persons resident said he did not like his . During further questioning as to why the resident did not like his resident responded " my is ugly", "he says ugly things to me and I am afraid of him". He was referring to resident #4, who was described as being aggressive during staff interview.

Upon discussion with the assistant administrator at this time, she said she could move the resident into another would get it done today. The resident was moved to # where staff also had better visual of the residents coming and going.

2. During the visit of it was observed that only 2 direct care staff were available to supervise 29 residents with memory . Due to the facility layout which includes a large common area, dining area and 2 hallway wings of residents (in the shape of an L) it was difficult for the 2 staff on duty to provide adequate supervision to all residents. These same 2 direct care staff were also responsible for passing medications.

It was observed that during the 12:00 noon med pass, one of the staff passing medications attention was diverted to intervene when a female resident (#10) at the dining was grabbing at other residents (#4) food. The staff commented that if he had not intervened that resident (#10) may have been hit by resident #4.

Resident #2 was observed to become agitated at 11:00am (yelling at a female resident) and after lunch while in the common area, his behavior escalated. He was yelling loudly and lashed out at a male staff and the assistant administrator, who was at the front desk answering phones and letting in visitors. The assistant administrator agreed they needed more staff and said she would try to get a 3pm to 11:00pm staff to come in early.

3. During record review for residents #1, 2, 3 & 4 there were no progress notes on file describing the current health status of these residents, their behavioral challenges or problems - although during interviews and observations it was apparent they existed. There was not any progress notes for resident #1 concerning medication problems brought to the facility's attention. There were no progress notes on file for resident #2 concerning his mood changes & behavioral outbursts witnessed & described by direct care staff. There was not any progress notes or incident report on file for resident #3 who reportedly (per staff interview at 4:00pm) swung at & hit a staff member on . There was not any progress notes on file concerning resident #4 who would be " inappropriate with female staff & residents.

Class III

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0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based upon observation & interview, the facility failed to ensure that residents were provided with an environment where they felt safe & secure.

Findings include:

During the visit of , resident #4 who was admitted to the facility on expressed to the surveyor during interview at 11:30am that the reason why he would go to other residents to lay down was because he did not like his own , saying he was afraid of his . During staff interviews (approximately 10:30am) staff stated that resident #3 (#4's) was aggressive and would hit with his fists. It wasn't until that resident #4 was moved to another . Resident #4 had been subjected to feeling threatened by his for 1 month.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based upon a review of the medication record and prescribed medications for resident #1, the facility failed to ensure that medication records were accurate and up to date.

Findings include:

A review on of the medication list provided by the health care practitioner for resident #1 revealed the resident was prescribed (on) 100mg., take 1 & 1/2 tabs, every 12 hours . A review of the facility medication observation record (MOR) for the month of 2013 revealed this medication was not recorded on the MOR. Further the MOR reflected that the resident did not receive his ER (prescribed to be given 2 tabs at bedtime) on , & at bedtime. The electronic medication record reflected "N" for those days. The MOR did not reflect the resident received his 40mg. tab (to be given 1/2 tab at bedtime) on & . The MOR did not reflect the resident received his 2mg. (to be given 1 tab at bedtime) on & .

During interview with the resident at about 11:00 am resident #1 said he has not been receiving his medications at night. He further said he gets his medications during the day, the problems with his medications only occur during the 8PM medications.

During staff interview (at 11:30 & 3:30pm) the facility recently went to a computerized system for medication pass. As a result the staff are not yet used to the program. When questioned the meaning of "N" recorded on the MOR for the pm dosages it was stated it means that the resident either did not receive their medications within the required timeframe, that the system crashed or that the resident did not receive it at all.

The assistant administrator contacted the pharmacy at about 5:30pm on to have them update & correct the medication record to include the residents 100mg.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

- - - - - - -, 2013

Administrator
Royal Sun Park
312 E 124 Ave
Tampa, FL 33612

Dear Administrator:

Re: **CCR# 2013009929**

This letter reports the findings of a complaint survey that was conducted on , 2013, by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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