STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966353	12/09/2015
NAME OF PROVIDER OR SUPPLIER VILLAS AT SUNSET BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 7423 KAUAI LOOP NEW PORT RICHEY, FL 34653	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Assisted Living Facility Complaint

A complaint investigation (CCR# 2015009714) was conducted at Villas at Sunset Bay on [redacted]. The Villas at Sunset Bay, Assisted Living Facility, had a deficiency at the time of the visit.

0010 Admissions - Continued Residency

Based on interviews and record reviews the facility failed to ensure that 1 of 4 residents whose records were reviewed met the continued residency criteria as evidenced by a face-to-face examination being conducted by a health care provider with the results documented on an AHCA Form 1823.

Findings included:

Resident #3 was admitted to the facility on [redacted]. The most recent AHCA Form 1823 (Health Assessment) that could be located in the file was dated [redacted]. The Assessment showed that the resident was independent in dressing, eating, self-care and toileting and assistance with ambulation and transferring and supervision with bathing.

Facility records, hospice notes and hospital records were reviewed and included notes between [redacted] and [redacted]. Resident #3's diagnoses included [redacted] and Chronic Kidney [redacted] III. Her limitations were listed as "gait disturbance". [redacted] status was stable with early memory loss, [redacted]. Special precautions were listed as [redacted], low soft diet.

The Assessment also showed Lactose free diet under special diet instructions. The resident was on a regular diet with honey thickened liquids.

An interview was conducted with Staff B, who was a regular caregiver to Resident #3 during her stay in the facility. She stated that the resident required assistance with everything because she could not get up or down from a chair, toilet or bed without help. She would get tired easily and had her [redacted] on at all times. She stated that she knew the resident was on Hospice and that she may have received physical [redacted] at one time. She also stated that the resident was often on [redacted]. The resident would normally wait for assistance from staff but Staff B heard that she had a [redacted] because she got up on

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VILLAS AT SUNSET BAY	7423 KAUAI LOOP NEW PORT RICHEY, FL 34653

SUMMARY STATEMENT OF DEFICIENCIES
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her own to use the [illegible]. She was sometimes [illegible]

Hospice notes and Care Plans dated [illegible] 2014 to [illegible] 2014 revealed that the resident had poor safety awareness with increased [illegible] with several episodes of [illegible] exacerbation. She was in Chronic [illegible] Failure with fatigue and [illegible] with minimum exertion. There was an expected decline at a slow rate with evidence of decline in appetite and intake and weight loss. The documentation showed her as needing 1-2 person assistance with all ADL's.

Resident #3's condition had declined in recent months per Hospice notes. The facility records and AHCA Form 1823 did not contain documentation of the significant changes the resident was experiencing.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
Villas at Sunset Bay
7423 Kauai Loop
New Port Richey, FL 34653

RE: Revised Report CCR# 2015009714

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on [redacted], 2015, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiency. Submit summary and documents to the Field Office no later than [redacted], 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiency identified on your survey, which may include a desk review or onsite revisit.

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.

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

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

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547