AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966353	12/27/2016
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

Two complaint investigations, (CCR# 2016012639 and CCR# 2016014029) were conducted at Villas at Sunset Bay on . Villas at Sunset Bay, Assisted Living Facility, had deficiencies at the time of the investigation.

(License # 10594)

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on interview and record review, the facility failed to honor resident rights by providing a personal monthly fee for 1 (#12) of 1 resident receiving Medicaid Managed Care benefits (Medicaid).

Findings included:

Interviews were conducted with Administrator at 1:20 PM on and Business Office Liaison at 11:28 AM on concerning residents receiving Medicaid and they both stated that there was 1 resident involved. Administrator identified Resident #12 as a beneficiary. Both staff members stated that residents have not received a $54.00 monthly personal fee (to be used for personal items such as toiletries, haircuts, etc.). When asked why residents receiving Medicaid did not receive the monthly personal fee, Administrator stated that the facility ' s VP of Clinical indicated that they were not required to provide residents with the monthly $54.00 benefit.

A phone interview was conduct with the responsible party for Resident #12 who stated that they were not aware of the resident receiving the $54.00 monthly benefit.

A phone interview was conducted with Clinical Care Coordinator from Resident #12 ' s Medicaid Managed Care company who stated that assisted living facilities are required to provide a minimum of $54.00 a month to residents who receive Medicaid for personal expenses.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the facility failed to ensure that Medical Observation Records

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SUMMARY STATEMENT OF DEFICIENCIES
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(MORs) were accurate and free from omissions and errors for 3 (Resident #1, #3, and #11) of 5 residents sampled.

Findings included:

On at 3:06 PM during the resident record review for Residents #1, #3, and #11, it was revealed that there were dates for medications prescribed that were not initialed. Resident #1 ' s MORs showed the medication 10 mg-take 1 tablet by mouth at bedtime, and on / and 12/ , initials were omitted.

A review of Resident #3 ' s MORs revealed omitted initials for prescribed medication 250 mg- 4 times daily at 9 AM, 1 PM, 5 PM, and 9 PM on the dates of / and .

A review of Resident #11 ' s MORs showed the medication 10 MG-take 1 tablet by mouth once daily- effective / . The MORs revealed that Resident #11 was being given doses twice daily and electronically initialed for dates / / thru for 9 AM and 5 PM.

An interview with Administrator was conducted on at 3:27 PM regarding the inaccuracies of the MORs. Administrator acknowledged the omissions for Residents #1 and #3 and discrepancy concerning the number of required doses for Resident #11.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

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

RE: CCR# 2016012639 & CCR# 2016014029

Dear Administrator:

This letter reports the findings of two complaint surveys that were conducted on , 2016, by representative(s) 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. **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 deficiencies. Submit summary and documents to the Field Office no later than , 2017.** 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 deficiencies 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.

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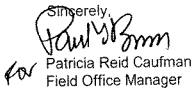
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

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,



for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90