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	AL11966301	**04/12/2017**
NAME OF PROVIDER OR SUPPLIER **SUN COAST RETREAT**	STREET ADDRESS, CITY, STATE, ZIP CODE **8151 TREELET COURT** **NEW PORT RICHEY, FL 34653**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Assisted Living Facility

Two unannounced complaint surveys, (CCR# 2017000972 & CCR# 2017001939) were conducted on .

The Sun Coast Retreat, Assisted Living Facility (License #10530), had deficiencies at the time of this visit specific to both complaint surveys, (CCR# 2017000972 & CCR# 2017001939).

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

Based on observation and interview, the facility failed to honor resident rights by not providing a safe living environment, free of hazards, and appropriate health care consistent with established and recognized standards within the community.

Findings included:

Upon facility entry at 10:00am, Surveyors observed an open a counter with free access to all. The open cupboards with latches for locks and one open lock hanging from an open cabinet; none of the doors were locked, and several were wide open. Shelves contained assorted items, such as over-the-counter medications, some labeled with resident names, some only with manufacturer labels, medical supplies, syringes, and . This storage the 'old med station' remained unsecured during the survey. Staff B stated: "We leave the door behind the med station open. There's no air in there and it gets stuffy."

During a medication observation on beginning at 12:10pm, Surveyor observed that Staff B left med cart unlocked and drawers open/ajar when turning away each time to take Residents #4, #6, and #7 their medications. Med tech stated, "I would have to keep going to [the other Med Tech] each time to get the keys."

During a medication, observation conducted on at 12:10pm, Surveyor observed that after Resident #4 took the prescribed , dose, Staff B placed the contaminated/used oral syringe back in the box with the , bottle and placed it back in the box without washing the syringe

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first. Staff B stated, "No, we don't wash it, it's hers."

A dining observation conducted during the lunch meal on found the meal not served in a safe manner. Surveyor observed the food cart pushed by a dietary aide through the small dining , around 2 large med carts while the 2 med techs were passing medication, between tables, around residents sitting in chairs or up walking around, and around 2 resident aides assisting residents. The dietary aide bumped into an empty chair, causing a salad to dump over, and then bumped into a chair that a resident was sitting in, causing a plate of food to onto the floor, which posed a potential risk for injury and/or . The food was not served in a sanitary manner, as the food was uncovered and exposed to air, posing risk of contaminated food.

Per interview with Staff B on at 12:15pm, Staff B confirmed that the dining , a risk for injury related to the over of the dining meals and medication pass in same area at same time. Staff B stated: "It's chaotic, but this is how it's done."

Per interview with Staff C on at 12:25pm, Staff C confirmed that the dining , a risk for injury related to the over of the dining meals and medication pass. Staff C stated, "Yes, it's too , but this is how we pass meds."

Per interview with the Administrator on at 5:45pm, the Administrator stated he has already been considering changes to the system of meds provision, such as bringing meds to resident rather than in area, and stated: "There is a big problem regarding medications and we have already begun to make changes."

Class III

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

Based on observation, record review, and interview, the facility failed to ensure proper maintenance of a daily Medication Observation Record (MOR) for each resident (20 of 20 sampled residents of facility with census of 73 in-house residents) who receives assistance with self-administration of medications. The facility failed to record each time medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors, and failed to immediately update the MORs each time medication is offered or administered. The facility also failed to accurately document counts at the time of provision.

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Findings included:

Per Surveyor review on of facility Medication Observation Records (MORs) for the month of , , 2017, 20 of 20 sampled resident MORs contained errors and omissions, including, but not limited to:

Resident #3 was prescribed , with instructions to take 1 tablet twice a day (8am & 5pm) - As of MOR review beginning at 10:30am, there were no initials indicating provision of this medication on at 5pm and at 8am. There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Resident #3 was prescribed , with instructions to take 1 tablet daily (8am) - As of MOR review beginning at 10:30am, there were no initials indicating provision of this medication on 4/9 and at 8am. There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Resident #3 was prescribed with instructions to take 1 tablet daily at bedtime (8pm) - As of MOR review beginning at 10:30am, there were no initials indicating provision of this medication on 4/5, 4/9, , & . There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Resident #3 was prescribed with instructions to take 1 tablet every 6 hours as needed for pain -- initialed as provided 17 times; listed on reverse of MOR as having been provided 24 times, including at 2pm & 6pm on 4/3 (not every 6 hours as prescribed), no provision time recorded on 4/4.

Resident #3 was prescribed with instructions to take 1 tablet every 8 hours as needed for muscle relaxer -- initialed as provided 1 time; listed on reverse of MOR as having been provided 3 times.

Resident #4 was prescribed Concentrate with instructions to take 1 ml by mouth at 6am, 12pm, 4pm, & 8:30pm. As of review beginning at 10:30am, there were no initials indicating provision of this medication on 4/1 at 12pm, 4pm, & 8:30pm, no initials indicating provision of this medication on 4/8 at 12pm, 4pm, & 8:30pm, no initials indicating provision of this medication on at 4pm, and no initials indicating provision of this medication on at 6am. There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

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Resident #4 was prescribed ... 100mg and ..., 25mg with instructions to take 1 tablet (of each) twice daily (8am & 5pm). As of review beginning at 10:30am, there were no initials indicating provision of these medications at 8am on 4/1, 4/8, & , and no initials indicating provision of these medications at 5pm on 4/1, 4/8 & . There was no listing on reverse of MOR regarding these medications having not been provided, no reasons or results, no medication provider initials.

Resident #4 was prescribed with instructions to take 2 tablets twice daily (8am & 5pm). As of review beginning at 10:30am, there were no initials indicating provision of this medication at 8am on 4/1, 4/8, 4/9, & and no initials indicating provision of this medication at 5pm on 4/8. There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Errors/omissions on Resident #4's , 2017 MOR included , , prescribed to be provided 2 times a day as needed for itch initialed as provided 7 times; listed on reverse of MOR as having been provided 8 times. , prescribed to be provided 2 times a day as needed for , initialed as provided 13 times; listed on reverse of MOR as having been provided 16 times. Tizandine prescribed to be provided 2 times a day as needed for muscle relaxer initialed as provided 5 times; listed on reverse of MOR as having been provided 13 times. with instructions to take 1 tablet at bedtime as needed for , initialed as provided 2 times; listed on reverse of MOR as having been provided 5 times.

Resident #7 was prescribed 6 medications to be provided at 5pm (, , , Cloazepam, , , , , &). As of review, there were no initials indicating provision of these medications on at 5pm and no listing on reverse of MOR regarding these medications having not been provided, no reasons or results, no medication provider initials.

Errors/omissions on Resident #7's , 2017 MOR included prescribed to be provided once daily as needed for pain initialed as provided 3 times; listed on reverse of MOR as having been provided 4 times. , prescribed to be provided 4 times daily as needed for pain initialed as provided 3 times; listed on reverse of MOR as having been provided 4 times.

Resident #11 was prescribed with physician instructions to take one tablet 3 times a day (8am, 12pm, & 5pm). Per MOR review beginning at 10:30am, staff initials for this medication were circled as not provided at 8am on 4/2 through , at 12pm on 4/2 through , and at 5pm on 4/1 through . There were no initials indicating provision of this medication at 5pm on . There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no

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medication provider initials.

Resident #11 was prescribed , eye drops with instructions to instill one drop into the left eye at bedtime (8pm) indefinitely. Initials were circled as having not been provided on 4/4, 4/6, & , and there were no initials indicating provision of this medication on 4/5, 4/7, 4/8, 4/9, & . There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Resident #12 was prescribed with physician instructions to take one tablet 3 times a day for pain (8am, 12pm, & 5pm). As of MOR review, there were no initials indicating provision of this medication at 5pm on 4/6 and . There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Resident #12 was prescribed with instructions to take one tablet at bedtime (8pm). As of MOR review, there were no initials indicating provision of this medication on 4/5, 4/8, & 4/9. There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Resident #12 was prescribed , with physician instructions to take one tablet 2 times a day (8am & 5pm). As of MOR review, there were no initials indicating provision of this medication on 4/8 and at 5pm. There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Resident #12 was prescribed , with physician instructions to take one tablet every 8 hours (6am, 2pm, & 10pm). As of MOR review beginning at 10:30am, there were no initials indicating provision of this medication on 4/8 at 2pm, 4/8, & at 10pm, and at 8am.

Resident #12 was prescribed with physician instructions to take one tablet 3 times a day (8am, 12pm, & 5pm). As of MOR review beginning at 10:30am, there were no initials indicating provision of this medication on 4/8 & at 5pm and at 8am.

On reverse of Resident #12's , 2017 MOR is documented that "all meds were refused" on " 8am-12, 8am-12, 5-8, 8am-12, 8am-12, 5p-8p, , , ." Medications were sporadically initialed as provided during the dates and times documented as refused, and no initials were circled to indicate the medications had not been provided.

Resident #13 was prescribed , with physician instructions to take one capsule 3 times a day (8am,

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12pm, & 5pm). As of MOR review beginning at 10:30am, there were no initials indicating provision of this medication on at 8am and at 5pm. There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Resident #13 was prescribed with physician instructions to take one tablet 2 times a day (8am & 5pm). As of MOR review beginning at 10:30am, there were no initials indicating provision of this medication on at 8am and at 5pm. There was no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

As of MOR review, none of Resident #13's medications prescribed to be provided on at 5pm were initialed as provided. There was no listing on reverse of MOR regarding these medications having not been provided, no reasons or results, no medication provider initials.

Resident #14 was prescribed 3 medications to be provided at 8am. As of MOR review, there were no initials indicating provision of this medication on and at 5pm. There was no listing on reverse of MOR regarding this medication having not been provided, no reason or res ult, no medication provider initials.

Resident #15 was prescribed 200mg tablets with physician instructions to take once daily (8am). MOR revealed initials circled as not provided , , & - There was no listing on reverse of MOR regarding this medication having not been provided, no reason or result, no medication provider initials.
Resident #15 was prescribed with physician instructions to take once daily in the evening (5pm). There were no initials indicating provision of this medication on 4/9 & - There was no listing on reverse of MOR regarding this medication having not been provided, no reason or result, no medication provider initials.

Resident #15 was prescribed with physician instructions to take 1 tablet by mouth twice a day (8am & 5pm) for 10 days (4/5-). MOR revealed initials circled as not provided at 5pm on as of review - There was no listing on reverse of MOR regarding this medication having not been provided, no reason or result, no medication provider initials.

Errors/omissions on Resident #15's 2017 MOR included prescribed to be provided every 6 hours as needed for pain initialed as provided 12 times; listed on reverse of MOR as having been provided 16 times. , prescribed to be provided at bedtime as needed for sleep initialed as provided 13 times; listed on reverse of MOR as having been provided 18 times.

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Errors/omissions on Resident #17's , 2017 MOR included , prescribed to be provided daily as needed for pain (parameters for use, number of times per day, limitations are not specified) -- initialed as provided 3 times on 4/1, 1 time on 4/2, 1 time on 4/4, and 2 times on 4/5, a total of 7 times--listed on reverse of MOR as having been provided 3 times.

Per review of Resident #18's , 2017 MOR prior to hospitalization, resident was not getting meds as prescribed and no explanation was provided for the omissions, including: On Page 16, Resident #18 was prescribed Acidophilus with physician instructions to take 1 capsule by mouth twice a day (8am & 5pm) - no initials indicating provision of this medication on 4/1 & 4/2 at 5pm; , with instructions to take 1 tablet every 8 hours for , (6am, 2pm, & 10pm) - no initials indicating provision of this medication at 6am on any day 4/1 through 4/4 and no initials indicating provision at 10pm on 4/1 & 4/2; with instructions to take 1 tablet at bedtime (8pm) - no initials indicating provision of this medication on 4/1 & 4/2 -- no listing on reverse of MOR regarding these medications having not been provided, no reasons or results, no medication provider initials.

Resident #18 was prescribed , with physician instructions to take 2 capsules every 8 hours for pain (7am, 3pm, & 11pm) - no initials indicating provision of this medication at 11pm on 4/1 & 4/2 - no listing on reverse of MOR regarding this medication having not been provided, no reason or results, no medication provider initials. Resident #18 was prescribed Ipratoprium/ with instructions to use 1 vial via every 6 hours for , (12am, 6am, 12pm, & 6pm) - no initials indicating provision of this medication on any day at 12am & 6am and no initials indicating provision at 6pm on 4/1 & 4/2 - no listing on reverse of MOR regarding this medication having not been provided except listed as not available on 4/1 & 4/2, no times specified, no reason or results, no medication provider initials.

Resident #18 was prescribed , , tablet with physician instructions to take 1 tablet at bedtime (8pm) for spasms - no initials indicating provision of this medication at 8pm on 4/1 & 4/2 - no listing on reverse of MOR regarding this medication having not been provided, no reason or results, no medication provider initials.

Resident #19 was prescribed to be provided 3 times a day (8am, 12pm, & 5pm) As of review, there were no initials indicating provision of this medication on at 5pm and no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.

Resident #19 was prescribed to be provided once daily (8am). MOR revealed initials circled as not provided on & - There was no listing on reverse of MOR regarding this medication having not been provided, no reason or result, no medication provider initials.

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Resident #19 was prescribed to be provided once daily at bedtime (8pm). MOR revealed initials circled as not provided 4/6 through and no initials indicating provision of this medication on . On reverse of MOR were 3 entries, listed as follows: at 8pm Not available - no results or initials, Not available - no results or initials, Not available - no results. This medication was not documented at time of attempted provision.

Resident #19 was prescribed , to be provided 2 times a day (8am & 5pm) As of review, there were no initials indicating provision of this medication on 4/6 & at 5pm and no listing on reverse of MOR regarding this medication having not been provided, no reasons or results, no medication provider initials.
Resident #20 was prescribed Elder Tonic Multi- liquid with physician instructions to take 1 Tablespoon 3 times daily before meals (8am, 12pm, & 6pm). As of review, there were no initials indicating provision of this medication on 4/9 at 6pm and no initials indicating provision of this medication on & at 8am and 12pm.

Resident #25 was prescribed , with instructions to take one tablet twice daily (8am & 5pm). As of review, there were no initials indicating provision of this medication on 4/9 at 5pm. Resident #25 was prescribed , with instructions to take 2 tablets twice daily (8am & 5pm). As of review, there were no initials indicating provision of this medication on 4/9 at 5pm.

Per review of the Count Sheet (NCS) records in use at the facility and actual medications supply, discrepancies included the following: Resident #3's NCS for , Patch indicated 5 patches available; the box only contained 4 patches. Resident #4's NCS for , 1mg Solution indicated that there was 1 box available; the box consisted of a nearly empty bottle. Resident #5's NCS for , indicated 69 tablets available; the bubble pack contained 68 tablets. Resident #6's NCS for , 15mg tablets indicated 12 tablets available; the bubble pack contained 11 tablets. Resident #8 NCS for , 5mg tablets indicated that there were 50 tablets available; the bubble pack contained 49 tablets. Resident #12's NCS for 50mg tablets indicated 42 tablets available; the bubble pack contained 41 tablets. Resident #21's NCS for , indicated 73 tablets available; the bubble pack contained 72 tablets. Resident #21's NCS for , indicated 99 tablets available; the bubble pack contained 98 tablets. Count Sheets also contained unexplainable, incorrect or incorrectly documented counts, such as Resident #17's counts: Surveyor observed Resident #17's pack in cabinet in Med Tech Supervisor's office. Instructions for this medication were to "Take 1 tablet by mouth daily as needed for pain in addition to routine." A sticky note on the card stated: "Hold until noon on ." Staff D, Med Tech Supervisor, stated he & the pharmacist decided to discontinue the med. Staff D stated: "No, I didn't call the doctor.

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The pharmacist said ok to holding the med." Surveyor observed another pack in Staff D's office cabinet containing partially used with instructions to take 1 tablet by mouth 3 times per day. Surveyor observed a 3rd pack in Staff D's office cabinet containing partially used with instructions to take 1 tablet by mouth daily as needed for pain in addition to routine. Medications had been taken from each pack. Count sheets revealed inaccurate counts, such as 85-1=83; 82-1=82; 82-1=80; 79-1=77; 76-1=76. Surveyors observed inaccurate monitoring of resident's controlled medications throughout facility records..

On at 10:50am, Surveyor observed Staff B initialing provision of residents' 8:00am meds. When Surveyor asked Staff B how she remembers what meds she provided at 8:00am, Staff B stated: "They pretty much get the same thing every day. I remember what I didn't give so I can circle it and put the issue."

Per interview with Staff B on at 11:30am, Staff B confirmed that are signed for on the count log at the end of the shift as having been given. Staff B stated: "Yes, we fill in (referring to signing for) the that we have given that shift at the end of the shift."

Per interview with Staff C on at 12:25pm, Staff C confirmed that are signed for on the count log at the end of the shift as having been given. Staff C stated: "At the end of the shift I'll sign for what I've given (referring to)."

Per interview with Staff D on at 12:35pm, Staff D confirmed that are signed for on the count log at the end of the shift as having been given. Staff D stated: "Oh, we sign for them (referring to) at the end of the shift."

Per interview with the Administrator on at 5:45pm, the Administrator stated: "There is a big problem regarding medications and we have already begun to make changes."

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to keep centrally stored medications in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times. The facility also failed to ensure that staff assisting residents with self-administration of medications have ready access to keys or codes to the medication storage areas at all times.

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Findings included:

During a tour of the facility on at 10:05am, Surveyors observed an open the 'old med station' with free access to all. The open cupboards with latches for locks, but no locks, and one open lock hanging from an open cabinet; none of the doors were locked, several were wide open <see photo evidence>. Shelves contained over-the-counter medications, some labeled with resident names, some only with manufacturer labels, medical supplies, syringes, and . Surveyors observed the area remain unsecured throughout the day of survey.
Per interview with Staff B, Staff B stated: "We leave the door behind the med station open; there's no air in there and it gets stuffy."

During a audit for medication cart A on Surveyor observed that Staff B had to retrieve keys from Staff C to access the cart because there is only one set of keys for two med carts (A and B), leaving meds unsecure in one cart while using carts . Staff B stated: "There is only one set of keys for both med carts; yes, for both med carts; we share keys, yes, even to the box."

Surveyor observed Staff B assisting residents with self-administration of medications on beginning at 12:10pm. Staff B left the med cart unlocked and drawers open/ajar when leaving the cart each time to take Residents #4, #6, and #7 their medications. Staff B stated: "I would have to keep going to [the other Med Tech] each time to get the keys."

Per interview with the Administrator on at 5:45pm, the Administrator stated he has already been considering changes to the system of meds provision, such as bringing meds to resident rather than in area, and stated: "There is a big problem regarding medications and we have already begun to make changes."

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, record review and interview, the facility failed to ensure that 2 of 5 medications prescribed to be provided as needed include specific directions including the circumstances under which it would be appropriate for the resident to request the medication and any limitations.

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Findings included:

Per Surveyor review on of facility Medication Observation Records (MORs) for the month of , , 2017, 2 of 5 medications prescribed to be given as needed did not include complete orders: Resident #17's MOR included prescribed to be provided daily as needed for pain. There were no parameters for use, number of times per day, or limitations specified. This medication was initialed as provided 3 times on 4/1, 1 time on 4/2, 1 time on 4/4, and 2 times on 4/5, a total of 7 times; listed on reverse of MOR as having been provided 3 times.

Resident #18's MOR included "Oxy" handwritten as PRN - full medication name, strength, directions & parameters for use, circumstances under which it would be appropriate for the resident to request the medication and any limitations were not specified. This medication was initialed as provided on 4/3 & written on reverse as "Oxy" provided--no full medication name, reason, or result written.

Per interview with the Administrator on at 5:45pm, the Administrator stated: "There is a big problem regarding medications and we have already begun to make changes."

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on interview and record review, the facility failed to provide or arrange a required 1-hour in-service training on control for staff who provide direct care to residents for 3 Staff (B, C, and D) of 3 sampled Staff.

Findings included:

An employee record review conducted on revealed that Staff B, hired on , did not have the required 1-hour in-service control training.

An employee record review conducted on revealed that Staff C, hired on , did not have the required 1-hour in-service control training.

An employee record review conducted on revealed that Staff D, hired on , did not have

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the required 1-hour in-service control training.

control concerns were identified at the facility throughout survey.

An interview conducted on at 4:15pm with Assistant Administrator confirmed that the employees did not have the 1-hour control in-service training. The Assistant Administrator stated: "None of the employees have that (referring to the control training); I thought that was the /-borne training."

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966301	**04/12/2017**
NAME OF PROVIDER OR SUPPLIER **SUN COAST RETREAT**	STREET ADDRESS, CITY, STATE, ZIP CODE **8151 TREELET COURT** **NEW PORT RICHEY, FL 34653**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on observation, record review, and interview, the facility failed to maintain the employment status of all employees within the Background Screening Clearinghouse, including Initial employment status and any changes in status within 10 business days, for 6 of 11 employees providing direct care services for a current census of 73 in-house residents.

Findings included:

On , the Assistant Administrator provided lists & schedules of all facility employees. Staff A through Staff K are listed as current facility employees providing resident care services.

Per interviews with Staff B & C at the facility on , both stated they are Resident Care Aides/Med Techs. Surveyor observed Staff B & C assisting residents with self-administration of medications on the day of visit. Per interview with & observation of Staff D, he supervises Med Techs and assists residents with self-administration of medications. Staff A, B & C are listed on the facility's "Med Tech Work Schedule."

Staff G, Staff I, & Staff K are listed on the facility's Resident Aide Work Schedule and confirmed by the Assistant Administrator on as employees who provide direct resident care services.

Per employee record reviews conducted at the facility on , Staff B began facility employment on , Staff C on , Staff D on , Staff G on , Staff I on , and Staff K on .

Per review of the facility's Employee Roster on the AHCA Background Screening site, Staff B, C, D, G, I, & K are not listed on the roster.

Per interview with the Assistant Administrator on at 2:45pm, the Assistant Administrator stated she maintains the facility's Background Screening site but may not have added the new employees yet.

Unclassed