STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942977	**12/21/2017**
NAME OF PROVIDER OR SUPPLIER **ROYAL SUN PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **312 E 124 AVE** **TAMPA, FL 33612**	

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

0000 - Initial Comments

Assisted Living Facility

Amended

An unannounced biennial state licensure survey with Limited Nursing Services (LNS) was conducted on , in conjunction with a complaint investigation. The Royal Sun Park, Assisted Living Facility, (License # 6124), had deficiencies at the time of this visit.

Tag 0009 was administratively deleted on .

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on records review and interviews, the facility failed to maintain an accurate and up to date Resident Health Assessment, AHCA Form 1823, which would accurately assess the resident for appropriateness of placement in the facility for 1 of 2 residents reviewed.

Findings included:

A record review of Resident #8's records was conducted on . Resident #8 was receiving hospice services. During the records review, it was revealed that the resident's records contained 2 different Form 1823 Assessments, both dated on . The 1823s dated were the most recent health assessments in the resident's records. One 1823 assessment was located in the resident's medical records and the other 1823 assessment was located in the resident's hospice records, which the facility kept in two separate binders. Both 1823 assessments were reviewed in conjunction with the facility's biennial licensure review. Based on the records review alone, it could not be determined which 1823 assessment was more accurate and truly reflective of the resident's current condition because the 2 records had the same date and were both signed by the same health care provider, however they contained different information vital to the facility determination of whether or not Resident #8 met the requirements for continued residency in the facility (photographic evidence provided).

The records review of both of Resident #8's 1823 health assessments dated revealed

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inconsistencies between the 2 records in the area of type of assistance needed for medications. One 1823 said "needs assistance with medication self-administration" and one 1823 stated on the first page that the resident required "medication administration". On page 4 of both 1823 assessments, the form is checked that the resident both "needs assistance with self-administration of medication" and "needs medication administration".

In an interview with the Resident Care Director of the facility on at 1:30pm while conducting an observation of Resident #8 in resident's , the Resident Care Director stated that Resident #8 requires medication administration, described as crushing medications and mixing them with a food, such as applesauce or pudding, placing the mixture on a spoon and inserting into the resident's mouth. The Resident Care Director stated that Resident #8 was not capable of picking up a spoon and inserting medications into the resident's own mouth.

In an interview with the Hospice Nurse caring for Resident #8, on at 3:45pm, the Hospice Nurse stated that the nurse visited Resident #8 on in the facility and conducted an assessment of the resident. The Hospice Nurse stated that Resident #8 was not capable of taking whole pills and that any pills needed to be crushed, mixed into a substance, such as applesauce, and spooned into the resident's mouth because the resident was not capable of picking up a spoon and inserting it into the resident's mouth.

The records review of both of Resident #8's 1823 health assessments dated revealed inconsistency between the 2 records in the area of whether or not the resident required 24-hour nursing supervision. One 1823 was marked yes, that the resident requires 24-hour nursing or , , care and the other one was marked no, that the resident did not require 24-hour nursing of , , care.

The records review of both of Resident #8's 1823 health assessments dated revealed inconsistency between the 2 records in the area of Activities of Daily Living (ADL) Levels. The ADL levels are: independent, supervision, assistance or total care. One 1823 was marked that the resident only required "assistance" with all ADLs. The other one stated that the resident required "total" care with bathing, dressing, self-care, toileting and transferring.

The records review of both of Resident #8's 1823 health assessments dated revealed inconsistency between the 2 records in the area of weight records. One 1823 indicated that the resident's weight on was 68 pounds and the other one indicated that the resident weighed 124 pounds on .

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Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on records review and interviews, the facility failed to insure a resident's appropriateness of placement in the facility for 1 of 2 residents reviewed (Resident #8).

Findings included:

A record review of Resident #8's records was conducted on . Resident #8 was receiving hospice services. During the records review, it was revealed that the resident's records contained two different Form 1823 Assessments, both dated on . The 1823s dated were the most recent health assessments in the resident's records. One 1823 assessment was located in the resident's medical records and the other 1823 assessment was located in the resident's hospice records, which the facility kept in two separate binders. Both 1823 assessments were reviewed in conjunction with the facility's biennial licensure review. Based on the records review alone, it could not be determined which 1823 assessment was more accurate and truly reflective of the resident's current condition because the two records had the same date and were both signed by the same health care provider, however they contained different information vital to the facility determination of whether or not Resident #8 met the requirements for continued residency in the facility.

The records review of both of Resident #8's 1823 health assessments dated revealed inconsistencies between the 2 records in the area of type of assistance needed for medications. One 1823 said "needs assistance with medication self-administration" and one 1823 clearly stated on the first page that the resident required "medication administration". On page 4 of both 1823 assessments, the form is checked that the resident both "needs assistance with self-administration of medication" and "needs medication administration".

The records review of both of Resident #8's 1823 health assessments dated revealed inconsistency between the 2 records in the area of whether or not the resident required 24-hour nursing supervision. One 1823 was marked yes, that the resident requires 24-hour nursing or care and the other one was marked no, that the resident did not require 24-hour nursing of care.

The records review of both of Resident #8's 1823 health assessments dated revealed inconsistency between the 2 records in the area of Activities of Daily Living (ADL) Levels. The ADL levels are: independent, supervision, assistance or total care. One 1823 was marked that the resident only

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required "assistance" with all ADLs. The other one stated that the resident required "total" care with bathing, dressing, self-care, toileting and transferring.

In an interview with the Resident Care Director of the facility on at 1:30pm while conducting an observation of Resident #8 in resident's , the Resident Care Director stated that Resident #8 requires medication administration, described as crushing medications and mixing them with a food, such as applesauce or pudding, placing the mixture on a spoon and inserting into the resident's mouth. The Resident Care Director stated that Resident #8 was not capable of picking up a spoon and inserting medications into the resident's mouth. The Resident Care Director stated that Resident #8 requires medications that are scheduled every day at various scheduled times per day, as reflected on the medication observation record. The Resident Care Director stated that the facility only had unlicensed Med Technicians (Med Techs) in its employ for providing medications to residents and that the Med Techs were spoon feeding medications to Resident #8.

In an interview with the Hospice Nurse caring for Resident #8, on at 3:45pm, the Hospice Nurse stated that the nurse visited Resident #8 on in the facility and conducted an assessment of the resident. The Hospice Nurse stated that Resident #8 was not capable of taking whole pills that and pills needed to be crushed, mixed into a substance, such as applesauce, and spooned into the resident's mouth because the resident was not capable of picking up a spoon and inserting it into the resident's own mouth. The Hospice Nurse stated that the interdisciplinary plan currently in effect was dated and that Resident #8's plan was to have a hospice nurse come to the facility 1 time per week for an assessment and 2 times per week to provide care and that a home health aide comes twice per week to provide care to the resident. The Hospice Nurse stated that the current interdisciplinary plan states that Resident #8 requires "assistance" with medications, however that was not correct because the resident is "dependent" upon someone to give medications as describes above. The Hospice Nurse stated Hospice plans to make changes to the interdisciplinary plan to better reflect Resident #8's current needs on the next scheduled visit to the facility.

In an interview with the Administrator at 2:00pm on , the Administrator stated that the facility does not employ licensed nurses on a full time basis that would be available to administer medications to residents every day around the clock, as needed. The facility has one licensed nurse who acts as the Resident Care Director and the Resident Care Director is not at the facility every day or on every shift.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

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Based on records review and interviews, the facility failed to provide a staff member licensed to administer medications to a resident who required medication administration for 1 of 1 residents.

Findings included:

A record review of Resident #8's records was conducted on . Resident #8 was receiving hospice services. During the records review, it was revealed that the resident's records contained 2 different Form 1823 Assessments, both dated on . The 1823s dated were the most recent health assessments in the resident's records. One 1823 assessment was located in the resident's medical records and the other 1823 assessment was located in the resident's hospice records, which the facility kept in 2 separate binders. Both 1823 assessments were reviewed in conjunction with the facility's biennial licensure review.

The records review of both of Resident #8's 1823 health assessments dated revealed inconsistencies between the 2 records in the area of type of assistance needed for medications. One 1823 said "needs assistance with medication self-administration" and one 1823 clearly stated on the first page that the resident required "medication administration". On page 4 of both 1823 assessments, the form is checked that the resident both "needs assistance with self-administration of medication" and "needs medication administration" (photographic evidence provided.)

In an interview with the Resident Care Director of the facility on at 1:30pm while conducting an observation of Resident #8 in resident's , the Resident Care Director stated that Resident #8 requires medication administration, described as crushing medications and mixing them with a food, such as applesauce or pudding, placing the mixture on a spoon and inserting into the resident's mouth. The Resident Care Director stated that Resident #8 was not capable of picking up a spoon and inserting medications into the resident's mouth. The Resident Care Director stated that Resident #8 requires medications that are scheduled every day at various scheduled times per day, as reflected on the medication observation record located in the resident's records. The Resident Care Director stated that the facility only had unlicensed Medication Technicians (Med Techs) in its employ for providing medications to residents and that the Med Techs were spoon feeding medications to Resident #8.

In an interview with the Administrator at 2:00pm on , the Administrator stated that the facility does not employ licensed nurses on a full time basis that would be available to administer medications to residents every day around the clock, as needed by Resident #8. The facility has one licensed nurse who acts as the Resident Care Director and the Resident Care Director is not at the facility every day or

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on every shift.

Class III