STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966353	R 01/31/2018
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

A revisit to a complaint investigation, (CCR# 2017014333), was conducted in conjunction with a Biennial survey at Villas at Sunset Bay on Villas at Sunset Bay, Assisted Living Facility, had deficiencies at the time of the investigation.

(License # 10594)

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

Based on record review and interview, the facility failed to ensure that Medical Observation Records (MORs) were immediately updated each time medication was offered to four Residents (#9, #11, #12, and #13) of six sampled Residents who require assistance with self-administration of medication.

Findings Included:

A MOR audit for Resident #9 conducted on revealed medications (meds) not signed as given and no reason given that the med was not given for 50mcg on @7am.

A MOR audit for Resident #11 conducted on revealed meds not signed as given and no reason documented that the med was not given for Methadone 5mg tablet on at 07:00am.

A MOR audit for Resident #12 conducted on revealed meds not signed as given and no reason documented that the med was not given for the following meds:
- 20mg on at 09:00pm
- 0.5mg tablet on @04:00pm and @10pm
- Powder on
- 72mcg capsule for through at 09:00am
- 40mg for through @09:00am
- 10mg tablet on @03:00pm

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A MOR audit for Resident #13 conducted on revealed meds not signed as given and no reason documented that the med was not given for 50mg for through .

During a Staff interview with the Regional Nurse conducted on , the Regional Nurse acknowledged and confirmed the omitted documentation for Residents #9, # 11, #12, and #13. The Regional Nurse stated that, "I can see this" and did not provide an explanation.

Class III

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

Based on observation, interview and record review, the facility failed to ensure that (1) prescriptions filled or refilled in a timely manner and, (2) medications properly labeled and dispensed for two Residents (#8 and #11) of six sampled Residents, who need assistance with self-administration of medication (med).

Findings Included:

During a med pass, observation conducted on at 12:15pm discovered that Resident #8's med pack label did not match the Electronic Medication Observation Record (EMOR). The label stated ' 50mg tablet take one tab four times every day'. The EMOR stated ' 50mg tablet take one tab three times every day at 09:00am, 01:00pm, and 05:00pm.

An audit of Resident #8's Count Sheet (See Photographic Evidence4) conducted on revealed that 50mg was not given as prescribed. On (See Photographic Evidence1) the admission med list stated that ' 50mg tablet take one tab by mouth three times every day specifically at 06:00am - 04:00pm - 08:00pm'. Resident #8 received 50mg most often at 08:00am, 01:00pm, and 05:00pm from through . On , Resident #8 received two tablets at 08:00am. On , Resident #8 received two tablets at 08:00am as well as one tablet at 01:00pm and 05:00pm. On , Resident #8 received a tablet at 08:00am, 02:00pm, and 04:00pm.

A review of Resident #8's prescription orders conducted on discovered that a

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clarification order sent from the facility to pharmacy on stated ' 50mg tablet take one tablet by mouth four times every day." No specific times noted and no hard copy paper prescription were provided for review.

An audit of Resident #8's Count Sheet (See Photographic Evidence4) conducted on revealed that 50mg was not given as prescribed. was given three times every day between and scheduled for 09:00am, 01:00pm, and 05:00pm. On , Resident #8 received a tablet at 08:00am, 01:00, and 09:00pm. On , Resident #8 received two tablets at 09:00am and one tablet at 08:00pm. On , Resident #8 received two tablets at 09:00am and one tablet at 05:00pm. On , Resident #8 received one at 08:00am and 01:00pm and two tablets at 05:00pm.

A review of Resident #8's prescription order conducted on revealed that on , Resident #8 received a new order for 50mg tablet one tab by mouth three times every day (See Photographic Evidence3).

An audit of Resident #8's Count Sheet (See Photographic Evidence4) conducted on revealed that on 50mg one tablet was signed as given at 08:00am, 02:00pm, and twice at 04:55pm. One of the 04:55pm signatures crossed out as "error." However, one 50mg tablet wasdeducted from the count. No reason/explanation given as to what happened to the tablet.

An EMOR review for Resident #11 conducted on revealed that Resident #11 had several meds documented as not given due to "not available". No explanation found as to measures taken by the facility to get Resident #11's meds filled or refilled, which included the following meds:
- , 125mg for through
- , 2mg on at 01:00pm and 05:00pm; and, at 09:00am, 01:00pm, and 05:00pm
- Methadone 5mg on at 07:00pm; and, at 07:00am and 07:00pm
- Ensure Nutrition Shake on at 05:00pm
- -S on at 05:00pm; and, 09:00am

During a Staff interview with the Regional Nurse conducted on at 01:45pm, the Regional Nurse acknowledged and confirmed the discrepancies for Resident #8's count sheet and label and orders. The Regional Nurse also acknowledged and confirmed that Resident # 11 had multiple meds marked as not given due to 'not available'. The Regional Nurse stated that, "I can see this" and did not provide an explanation.

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Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on record review, observation, and interview the facility failed to ensure that deficient practice related to medication requirements in the facility was corrected on the follow-up visit.

Findings Included:

In review of the Class III deficiencies cited during a Complaint Investigation conducted on two (A0054 and A0056) medication deficiencies werecited.

During a Revisit Survey conducted on 01/31/2018, both Class III medication deficiencies (A0054 and A0056) not corrected as required.

The facility had ongoing deficient practice related to updating Medication Observation Records (MORs) accurately and providing medications as ordered by a health care provider.

The facility is required to hire a registered nurse or pharmacy consultant.

Class III