Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942892	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE	11722 NORTH 17TH STREET TAMPA, FL 33612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Facility An abbreviated biennial state licensure survey with limited nursing services (LNS) was completed on / . The Sunrise Village, assisted living facility, had deficiencies found at the time of the visit.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met	A 008		

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A 008	Continued From page 1	A 008		

in an assisted living facility; and
8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.
2. The facility administrator, or designee, must

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A 008	Continued From page 2 complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a do-not- order for residents who do not wish to be administered in the case of or	A 008		

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A 008	Continued From page 3 (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure the required health assessment form (1823) was available and complete for 1 (Resident #1) of 3 sampled residents who experienced a significant change, had been sent out of the facility and then returned to the facility, which contributed to staff not having the most current medication orders that resulted in medication errors. Findings include: A record review revealed Resident #1 was admitted to the facility on . Diagnoses listed on the 1823 included: muscle secondary to Parkinson's, ( ), chronic kidney ( ), and . Medication orders were included with the assessment. A further record review revealed the resident was	A 008		

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A 008	Continued From page 4	A 008		

sent to the hospital on after complaining of and trouble breathing. On the resident was sent back to the facility from rehabilitation with only a resident transfer sheet and a "draft" only medication list. There was no new 1823 and no documentation that it had been requested.

Observation of the Resident #1 during the med pass at 11:35am revealed an appropriately dressed and (clean shaven) male sitting in a wheelchair in the nurses/med tech station. An interview with him during the med pass revealed he was alert and oriented and familiar with his medications.

Interview with Staff A (lead med tech supervisor) on at approximately 11:40am during the noon med pass revealed the most current 1823 was dated . She acknowledged there was no 1823 received when the resident returned to the facility on and she could not explain why one had not been sent with the resident.

An interview with the administrator on at approximately 1:30pm revealed it was the responsibility of the lead med tech supervisor or other med tech supervisors (when the lead was not on duty) to make note of all medication changes on the medication observation records (MORs) each time a resident returns to the facility (after doctor appointments or hospitalizations/rehab stays) and to seek clarification when necessary. She further stated it was ultimately her (the administrator's) responsibility to assure the 1823's are completed and available in the resident records after experiencing a significant change. The administrator did call the rehab center that had

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A 008	Continued From page 5 discharged the resident (during the survey) and was sent a completed and signed 1823 for the resident, but there was no date of completion and therefore could not be considered valid. CLASS III	A 008		
A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least , trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container. (c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.	A 052		

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A 052	Continued From page 6 (d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility; 2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record; 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging; (e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. (f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition. (4) Assistance with self-administration does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route.	A 052		

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A 052	Continued From page 7 (c) Administration of medications through intermittent positive pressure breathing machines or a [illegible]. (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of [illegible] preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) [illegible], [illegible], or [illegible] preparations. (h) Medications ordered by the physician or health care professional with prescriptive authority to be given " as needed, " unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, 2 medication techs (Staff A and Staff B) failed to recognize a problem with the way a prescribed medication was packaged for 1 (Resident #1) of 5 residents observed during the noon medication pass which resulted in Staff A giving an incorrect dose of a prescribed medication which could cause adverse effects. Findings include: Observation of Staff A at 11:30am revealed she checked the medication observation record for medications due at noon and proceeded to assist the resident with them. The 4 medications due based on the [illegible] medication observation record (MOR) included:	A 052		

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A 052	Continued From page 8 Robinirole 0.25mg tab, take 1 tab by mouth 3 times daily and was scheduled at 7:00a, 12:00n, 5:00pm Omega 3 Fish oil 1,000mg cap, take 3 caps by mouth 3 x daily and was scheduled at 7:00am, 12:00n and 5:00pm. HBR 20mg tab, take 1 tab by mouth daily, scheduled at 12:00n inhaler, inhale 1 puff by mouth every 6 hours, scheduled at 7:00am, 12:00pm and 6:00pm Continued observation of Staff A revealed she did not check the label of the Robinirole prior to assisting with the medication. A yellow pill was taken from the bottle and placed in a medication cup with the other medications that were due and the resident was observed to swallow them. Review of the label on the Robinirole bottle had a different dose (0.5mg) instead of what the MOR had (0.25mg). The label had the words, "note change in tablet strength". The prescription was filled (while the resident was in the hospital/rehab). The actual Robinirole bottle label was dated and described the 0.5mg tablets as being yellow with the numbers 54 and 337 below it. To complicate matters more, observation of the inside of the bottle had both yellow and white pills in it. The white pills had the number 54 and 511 under it. An internet search identified the white pills as Robinirole 0.25 mg (one half the dose of the yellow tablets). An interview with Staff A on at approximately 11:45am revealed she was not aware that the different color of the pills in the Robinirole bottle indicated that they were a different strength. She denied placing the white pills into the bottle labeled for the yellow pills. She	A 052		

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A 052	Continued From page 9 was unsure if the bottle came with the resident upon his return to the facility from rehab on [redacted]. She did not notice that the MOR had a different dose than than the bottle had either but acknowledged the MOR did not match the bottle. She removed the bottle from the residents other medications and placed a call to the prescribing physician to notify of the error and to seek clarification of the order during the survey. An interview with the administrator on [redacted]/2013 at approximately 2:00pm revealed an acknowledgement of the yellow and white pills in the same Robinirole bottle and could not explain how it happened. Class III	A 052		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known [redacted] the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time	A 054		

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A 054	Continued From page 10	A 054		

the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.
(c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to assure the medication observation records (MOR) matched the current orders and labels for 1 (Resident #1) of 5 residents observed during the noon medication pass and medication reconciliation causing on the part of the medication technicians and placed the resident at risk for adverse outcomes based on possibly giving the wrong dose..

Findings include:

A record review revealed Resident #1 had an order (dated) just prior to his return on from rehab for: , ( ) HBR 20mg, take 1/2 tablet daily (10mg). It was scheduled for 7:00am. Review of the MOR had the order listed on a computer generated transcription with a different dose: HBR 20mg, take 1 tab daily. Observation of the labeled bottle read: , HBR 20mg, take 1/2 tab daily. Observation of the medication on hand revealed the pills were scored which meant trained med tech staff were allowed to break the tablets in half, however the MOR never reflected the change from 1 tab to 1/2, therefore daily documentation looked as if

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A 054	Continued From page 11 the resident received 1 full tablet (20mg) instead of 10mg. An interview with the lead med tech supervisor (Staff A) on revealed she had not noticed the transcription error in the MOR but said she gave the correct dose of 1/2 pill daily. Additionally she said it was her responsibility as well as the other med techs to transcribe medication orders onto the MOR as soon as med changes are made. She could not explain why it had been missed. An interview with another med tech supervisor (Staff B) on at approximately 3:00pm revealed she also gave 1/2 tab of the ordered and had not noticed the MOR was inaccurate. Further interview revealed it was her responsibility to assure all medication orders and changes are made on the MORs. An interview with the administrator on at approximately 3:30pm revealed the policy of the facility is to have the trained medication techs immediately transfer order changes and new orders upon receipt to the current MOR. She said the facility also participates in a pilot program with a pharmacist visiting on a monthly basis to reconcile the medications/orders of approximately 10 residents medications each time. Additionally, she said staff receive frequent medication updates which was confirmed during sampled employee reviews including Staff A and B. She acknowledged the facility's medication policy had not been followed. Class III	A 054		
A 152	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other	A 152		

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A 152	Continued From page 12 (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, chest or other furniture designed for storage of personal effects; 4. A table, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be	A 152		

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A 152	Continued From page 13	A 152		

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to complete the required annual fire inspection or clear all violations during the annual fire inspection which placed the residents at an increased risk of injury during a potential fire.

Findings include:

A review of the facility's annual fire inspection report dated on / revealed a violation for lacking the required fire sprinkler service and tag. The report also indicated that the administrator needed to "call for re-inspection for sprinkler annual when complete." There was no documentation that the re-inspection was completed. There was also no documentation of an annual fire inspection in 2011.
In the interview with the administrator on / at approximately 2:00pm, she stated that the sprinkler violation on the fire inspection report dated dealt only with the sprinklers added on the front porch of the facility. She stated the sprinkler inspection had been done, but the company forgot to include the tag. She also stated she had provided proof of the fire sprinkler service and tag to the fire department, but did not receive another fire inspection report that cleared the violation. Additionally, the administrator stated that the fire department did not come to inspect the facility in 2011.
Class III

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Sunrise Village
11722 North 17th Street
Tampa, FL 33612

Dear Administrator:

This letter reports the findings of an abbreviated biennial state licensure survey with limited nursing services (LNS) that was conducted on , 2013, by a representative of this office.

Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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.

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

Sincerely,

Patricia Reid Caufman
for Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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