STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953686	10/22/2015
NAME OF PROVIDER OR SUPPLIER **NEW PORT INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **6120 CONGRESS STREET** **NEW PORT RICHEY, FL 34652**	

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

0000 Initial Comments

Assisted Living Facility

A biennial state licensure survey with limited nursing services (LNS) was conducted on .

New Port Inn, assisted living facility, had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and interview the facility failed to ensure the accuracy of an AHCA Form 1823 Health Assessment for 1 of 3 (#12) sampled resident records, documenting what type of assistance is required for the administration of medications.

Findings include:

A review of resident #12 (1823-health assessment) dated showed in section (b) a check next to "yes" box that reads " needs assistance with self-administration of medication" However, also showed in section (b) a check next to "No" next to the box that reads," does the individual needs help with taking his or her medication " Additional hand written notes noted on section (b) reads:" should be able to take on own, we administer help not sure about medication complic if self-medicate." Therefore it is not clear as to which type of medication assistance is needed for resident #12.

During an interview with staff A, staff A reviewed record with surveyor and confirmed findings. Staff stated "yes I agree this is confusing, as to what type of assistance is needed for this resident.

No further documentation was provided to surveyor at this time.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview and record review, the facility failed to maintain a safe living environment, free from hazards related to storage for one ( ) out of three resident toured for storage.
Findings include:
On at 1:50 PM, during a tour of the Limited Nursing Services (LNS) Resident , 5 empty cylinders of were noted to be standing in the upright position along the wall, next to an

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electrical outlet. (See photo number one). Two full cylinders were observed, on their side, under a storage chest in the residents (see photo number two), next to the Residents chair.
During an interview with Staff A, she indicated that "that's the way it ' s always been".
An storage policy was requested at 3:45 PM, the Regional Nurse said that they don't have one it didn't exist.
The DON was informed of the storage in the residents ' . Staff A stated she had called the company that delivers the and ordered a stand for the cylinders, it will be delivered in two hours.

Class III

0055 Medication - Storage and Disposal

Based on interview, observation and record review, the facility failed to remove and keep seperate discontinued medications (30 milligram (mg) Extended Release (ER) tablet and ointment) from medication in current use in the medication cart for two (Resident # 1 and #2) of two residents being observed for medication pass.
Findings include:
1) A review of the Medication Observation Record (MOR) reveals the physician ordered 15 mg ER on upon her readmission from the hospital. Resident #2 received the previously ordered dosage of 30 milligrams on the following dates and times, after the order had been changed. The card started with 26 tablets, and the following tablets of 30mg ER were dispensed:
12 at 8AM and 5PM
13 at 8 AM and 5 PM
16 at 8 AM
20 at 8 AM
There were 17 tablets remaining in the card. During an interview with Staff B, she stated she didn ' t know what the Resident was getting instead of the 15 mg ER tablets, but she knows the resident wasn ' t in pain because of the increase in frequency of the other pain pill.
Documented on the back of the MOR are the dates and reason the 15mg ER tablet was not given:
8AM -reason-n/a
at 5PM -waiting for different milligram
8 AM -waiting for different milligram
at 8 AM -waiting for different milligram
At 1:20 PM an interview with a representative from the facility ' s ' pharmacy, they stated the reason

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they have not dispensed the medication is that they never received a hard copy of the prescription. The 30 mg tablet had been discontinued on when she was admitted to the hospital. They had an order for 15mg tablet, but received no hard copy of the prescription as is required by law for a schedule II .

In an interview with Staff A she stated she knew why the pharmacy wouldn ' t send the pills, because she already has some here. " I tried to get them from the nursing home she was at but they wouldn ' t give them to me, they said they don ' t do that, give out like that " .

2) During an observation of resident #1s medication assistance, Staff B brings a small clear plastic ziplock bag containing a mostly used tube of ointment in to the residents ' , and proceeds to rub the ointment on both of Resident # 1 ' s lower extremities after placing a towel on the bed, and assisting the resident with placing her legs on the bed. She said, this is your for the itchiness, for the . The skin on her lower legs was not discolored or broken.

The drug name(westcort) on the pharmacy label attached to the plastic bag had been crossed out in pen and the name of another drug ( ) was hand written on the label (see photo). Staff B doesn ' t know how that happened or why.

Staff B also realized that she had applied the wrong medication to both legs instead of just one. She said, that was my bad, I told her the wrong thing.

Physicians orders dated / / through / / indicate was discontinued on 10/9 and westcort discontinued / / .

Staff A later clarifying with physicians office- apply -polymicin to Left lower extremity once daily.

Observation and interview with the resident reveals no distress.

Class III

0056 Medication - Labeling and Orders

Based on observation, interview and record review the facility failed to provide pain medication ordered in a timely manner for one (# 2) out of three residents reviewed and altered a pharmacy label for a change in medication with no direction for use written on the label for one (# 1) resident of three residents reviewed during the medication observation task.

Findings include:

1) A review of the Medication Observation Record (MOR) for resident #2,reveals the physician ordered 15 mg ER on . It was also written on her Health Assessment form 1823 by the physician. As of , the resident had not yet received her ordered dosage of 15 milligram tablet twice a day.

At 1:20 PM an interview with a representative from the facility ' s pharmacy, they stated the reason they

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have not dispensed the medication is that they never received a hard copy of the prescription. The 30 mg tablet had been discontinued on when she was admitted to the hospital. They had an order for 15mg tablet on the 1823, but received no hard copy of the prescription as is required by law for a schedule II .

In an interview with Staff A she stated she knew why the pharmacy wouldn ' t send the pills, because she already has some here (referring to the 30mg ER tablet). " I tried to get them from the nursing home she was at but they wouldn ' t give them to me, they said they don ' t do that, give out like that " .

Resident observed resting comfortably in no distress.

2) During an observation of resident #1s medication assistance, Staff B brings a small clear plastic ziplock bag containing a mostly used tube of ointment in to the residents ' , and proceeds to rub the ointment on both of Resident # 1 ' s lower extremities after placing a towel on the bed, and assisting the resident with placing her legs on the bed. She said, this is your for the itchiness, for the . The skin on her lower legs was not discolored or broken.

The drug name(westcort) on the pharmacy label attached to the plastic bag had been crossed out in pen and the name of another drug ( ) was hand written on the label (see photo). Staff B doesn ' t know how that happened or why.

Staff B also realized that she had applied the wrong medication to both legs. She said, that was my bad, I told her the wrong thing.

Physicians orders dated / / through / / indicate was discontinued on 10/9 and westcort discontinued / / .

Staff A later clarifying with physicians office- apply -polymicin to Left lower extremity once daily.

Observation and interview with the resident reveals no distress.

Class III

0078 Staffing Standards - Staff

Based on interview and record review the facility failed to ensure that 1 of 3 sampled employees (C) was free from communicable within 30 days after beginning employed.

Finding include:

A review of the employee personnel records on revealed employee C was hired on . Employee C file showed Employee (C) file did not have documentation indicating she was free from communicable .

During an interview with Administrator on at 2:50 p.m., the Administrator reviewed staff (C) personnel file with surveyor and confirmed findings. The Administrator stated, " we ordered an chest x-ray on , but she refused to take it." The Administrator confirmed staff (C)currently provides

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direct care to residents while on the 3:00 p.m. to 11:00 p.m. shift since date of hire.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
New Port Inn
6120 Congress Street
New Port Richey, FL 34652

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited nursing services (LNS) that was conducted on , 2015, 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 , 2015.** 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.

St. Petersburg Field Office
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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,

Paul Brown

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547