STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953686	**05/22/2018**
NAME OF PROVIDER OR SUPPLIER **GRAND VILLA OF NEW PORT RICHEY**	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 complaint investigation (CCR 2018005405 and 2018007140) was conducted at Grand Villa of New Port Richey on . Grand Villa of New Port Richey had deficient practice at the time of the investigation.

(License #4832)

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

Based on record review and interview, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medication were filled or refilled in a timely manner for two (Resident #1 and Resident #6) of five sampled residents. The failure of the facility to ensure residents received medications prescribed for high , , failure, and water retention posed a direct threat to the residents.

Findings Included:

On , a review of medication observation records (MORs) for Resident #1 revealed the following medications were not provided (photographic evidence obtained):

- 10 mg not provided on to
- 12.5 mg not provided on to
- 25 mg not provided on to
- 10 mg not provided on to
- DR 40 mg not provided on to
- 50 mg not provided on to
- Probiotic Formula Cap not provided on to
- 325 mg not provided on to
- 500 mg not provided on to
- 81 mg not provided on to
- 1,000 Mcg not provided on to
- Oyster Shell -Vit D not provided on to
- 15 mg not provided on to

According to the 2014 Lippincott's Pocket Drug Guide for Nurses, is prescribed to

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treat high , by relaxing and improving flow. is prescribed to treat high , and failure and is used after a to improve the chance of survival. is prescribed to treat fluid retention and high , . is prescribed to lower to reduce risk of , is prescribe to treat high , , is prescribed for health.

A record review of Resident #1's record conducted on showed that emergency medical services ( ) was called on . According to the Resident #1's record, at 11:20 am on , was assessing the Resident #1 in their Resident #1 was sent out to a local hospital. Additional entries dated showed that Resident #1 was admitted to the hospital with exacerbated ( ) and NSTEMI (a medical term for a). Medical records obtained from the local hospital dated showed a resident discharge diagnosis for Resident #1 as NSTEMI ( ).

On , a review of MORs for Resident #6 revealed the following medications were not provided (photographic evidence obtained):
- o Rena-Vite Tablet was not provided on to and
- o , Hbr 10 mg was not provided on to and
- o 20 mg was not provided on to and
- o 3 mg was not provided on to and
- o 50 mg was not provided on to and
- o , Succ ER 25 was not provided on and
- o , , 100 mg was not provided on

A review conducted on of the facility's No Pass Policy and Procedure for medications dated , under the section Procedure, Medication Not Available (photographic evidence obtained) revealed the following:

- o The Resident Care Supervisor, Memory Care Supervisor or Shift Coordinator must follow up on status of the medication order to ensure resident receives timely.
- o If the medication is not received within three (3) days, the physician must be notified

During an interview conducted on at 10:37 am, Staff B stated that if a resident is without medication, the Director of Nursing (DON) or the Administrator is notified to get an emergency medication supply for at least 7 days.

During an interview conducted on at 11:00 am, Staff A stated that if a resident runs out of

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medication, the doctor is made aware and the facility gets the pharmacy to send a 7 day supply.

A phone interview was conducted with the Office Manager for Resident #1's primary care physician at 3:58 PM on . The Office Manager stated that they reviewed the physician's communication records and there was nothing on record concerning Resident #1 not having their medications from through .

During a phone interview conducted on at 4:09 pm with the advanced registered nurse practitioner (ARNP) that worked for Resident #1's primary care physician, they stated that they were not notified and that the resident's primary care physician had not been notified that Resident #1 had run out of medication on .

During an interview on at 4:41 pm with the Resident Care Supervisor, they confirmed that the facility should have obtained the medication and stated that they were not given approval to order an emergency supply of medication for Resident #1.

During the exit interview conducted on at 6:05 pm, the lack of follow-up in obtaining medications for Resident #1 and Resident #6 was discussed, including the subsequent emergency for Resident #1. The Regional Director of Operations acknowledged that the facility was responsible for obtaining the medications and should have purchased the medications for the residents.

Class II

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

Based on record review and interview, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medication were filled or refilled in a timely manner for two (Resident #1 and Resident #6) of five sampled residents. The failure of the facility to ensure residents received prescribed medications as ordered posed a direct threat to the residents.

Findings Included:

On , a review of medication observation records (MORs) for Resident #1 revealed the following medications were not provided (photographic evidence obtained):

- 10 mg not provided on to
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A record review conducted on showed that emergency medical services ( ) was called on . According to the Resident #1's record, at 11:20 am on was assessing the Resident #1 in their was sent out to a local hospital. Additional entries dated showed that Resident #1 was admitted to the hospital with exacerbated ( ) and NSTEMI (a medical term for a). Medical records obtained from the local hospital dated showed a resident discharge diagnosis for Resident #1 as NSTEMI ( ).

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o 50 mg was not provided on to and
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A review conducted on of the facility's No Pass Policy and Procedure dated , under the

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section Procedure, Medication Not Available (photographic evidence obtained) showed the following:
o The Resident Care Supervisor, Memory Care Supervisor or Shift Coordinator must follow up on status of the medication order to ensure resident receives timely.
o If the medication is not received within three (3) days, the physician must be notified

During an interview conducted on at 10:37 am, Staff B stated that if a resident is without medication, the DON or the Administrator is notified to get an emergency medication supply for at least 7 days.

During an interview conducted on at 11:00 am, Staff A stated that if a resident runs out of medication, the doctor is made aware and the facility gets the pharmacy to send a 7 day supply.

A phone interview was conducted with the Office Manager for Resident #1's primary care physician at 3:58 PM on . The Office Manager stated that they reviewed the physician's communication records and there was nothing on record concerning Resident #1 not having their medications from through .

During a phone interview conducted on at 4:09 pm with the advanced registered nurse practitioner (ARNP) that worked for Resident #1's primary care physician, they stated that they were not notified and that the resident's primary care physician had not been notified that Resident #1 had run out of medication on .

During an interview on at 4:41 pm with the Resident Care Supervisor, they confirmed that the facility should have obtained the medication and stated that they were not given the authority to order an emergency supply of medication for Resident #1.

During the exit Interview conducted on at 6:05 pm, the lack of obtaining medications for Resident #1 and Resident #6 was discussed, including the subsequent emergency for Resident #1. The Regional Director of Operations acknowledged that the facility was responsible for obtaining the medications and should have purchased the medications for the residents.

Due to the class II deficiency concerning facility practices regarding refills of medication, the facility shall be required to employ the consultation services of a licensed pharmacist or a registered nurse.

The consultant shall at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.

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This statement serves as notification of the above stated requirement.

Class III