STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953686	R 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF NEW PORT RICHEY	**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 revisit to complaint (CCR 2018005405) was conducted at Grand Villa of New Port Richey on in conjunction with a biennial survey. Grand Villa of New Port Richey had deficiencies at the time of the revisit.

(License #4832)

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, interview, and record review, the Facility failed to ensure proper assistance with inhaler use according to manufacturer's instructions. In addition, the Facility failed to assist with medications according to safe practice in control for four Residents (#8, #11, #12, and #13) of five sampled residents.

Findings Included:

During a medication review, with Resident #8, conducted on at 09:55am, Staff A was observed placing centrally stored medication packs on Resident #8's blanket on the bed. Resident #8 was in bed with shoes on the blanket at the time of the medication observation. Staff A did not use a barrier between the medication packs and Resident #8's blanket. Staff A then placed the potentially contaminated medication packs back in the central storage medication cart.

During a medication review, with Resident #11, conducted on at 11:48am, Staff B did not wash or sanitize their hands between assisting Residents #11 and #13 with oral medication.

During a medication review, with Resident #13, conducted on at 12:00pm, Staff B did not wash or sanitize their own hands before and after assisting Resident #13 with a ProAir Hydrofluoroalkane (HFA) Inhaler and failed to follow the manufacturer's instructions for the inhaler. Staff B prompted Resident #13 to wait three to four seconds before taking a second puff of the ordered ProAir HFA Inhaler. Staff B did not shake or have Resident #13 shake the ordered ProAir Inhaler before use. Staff B did not remind Resident #13 to rinse their mouth with water after both doses of the ordered ProAir HFA Inhaler. Staff B placed Resident #13's ProAir HFA Inhaler back in the central storage medication cart without washing/cleaning the mouthpiece.

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A review of the ProAir HFA Inhaler Manufacturer's Instructions, conducted on , revealed that 'Step 6 [states to] wait one minute, shake inhaler again, and repeat steps ...when you have finished all of your doses, rinse your mouth with water and spit the water out'. Rinsing the mouth out after use of the ProAir HFA Inhaler prevents the development of from Candidiasis or yeast . The Manufacturer's Instructions also stated that is very important to keep the plastic actuator clean ...completely clean the actuator once per week by holding it under running water for 30 seconds and let completely dry before using ...wash the mouth piece and dry it completely after using the inhaler'.

During a medication review, with Resident #12, conducted on at 12:07pm, Staff B did not wash or sanitized own hands before assisting Resident #12 with oral medication.

A review of the Center for Control (CDC) for preventing the spread of , conducted on , revealed that "wash[ing] hands between contact with different patients and after handling any , body fluids, secretions ..." used to prevent the spread or potential spread of .

An interview with the Resident Care Coordinator, conducted on at 12:25pm, revealed that per the Resident Care Coordinator, Medication Technicians (MTs) should wash their hands before and after a medication pass. MTs should sanitize between resident and rewash their hands after every third resident. MTs should wash their hands with any potential exposure to or body fluids. The Resident Care Coordinator denied having a Policy and Procedure for control practices for medication pass. The Resident Care Coordinator stated that medication packs taken into a resident's be "placed on a clean surface or a barrier to keep the medication packs from being contaminated." The Resident Care Coordinator stated that an inhaler mouthpiece should be washed "after each use."

Class III

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

Based on observation and record review, the Facility continues with deficient medication practice including failing to ensure proper assistance with inhaler use according to manufacturer's instruction and failed to assist with medication according to safe practice standards in control.

Findings Included:

During a medication review, with Staff A, conducted on at 09:55am, revealed that Staff A place Resident #8 medication packs on the blanket/bed. Resident #8 occupied the bed at the time. Staff A did

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

not provide a barrier between medication packs and Resident #8 blanket. Staff A placed Resident #8 medication packs back in the central storage medication cart.

A medication review, with Staff B, conducted on . . .. . at 11:48am, revealed that Staff B did not wash or sanitize own hands between assisting Resident #11 and #13 with oral medication. At 12:00pm, Staff B did not wash or sanitize own hands before and after assisting Resident #13 with ordered ProAir Hydrofluoroalkane (HFA) Inhaler. Staff B did not remind Resident #13 the proper time to wait (one minute) between doses of the ProAir HFA inhalant. Staff B did not remind Resident #13 to rinse mouth after using the ProAir HFA inhalant. Staff B placed Resident #13 ProAir HFA inhaler back in the central storage medication cart without cleaning the mouthpiece. At 12:07 pm Staff B did not wash or sanitized own hands before assisting Resident #12 with oral medication.

During a Complaint Investigation (CCR#: 2018005405 and 2018007140) conducted on , the Facility was cited for a Class II medication deficiency. The Facility continues to be required to employ or contract consultant services of a licensed pharmacist or a licensed registered nurse to provide at a minimum onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.
Class III