STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910790	**12/01/2015**
NAME OF PROVIDER OR SUPPLIER **SUMMIT AT NEW PORT RICHEY**	STREET ADDRESS, CITY, STATE, ZIP CODE **5539 CHARLES STREET NEW PORT RICHEY, FL 34653**	

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

0000 Initial Comments

Assisted Living Facility Complaint

A complaint investigation (CCR# 2015012324) was conducted at Summit at New Port Richey on / /. Summit at New Port Richey, Assisted Living Facility, had a deficiency at the time of the visit.

0027 Resident Care - Arrangement for Health Care

Based on interview and record review, the facility failed to show proof that residents were given a choice of home health companies to utilize for 3 (Resident #1, #2, and #3)of 4 records reviewed.

Findings include:

An interview with the resident care coordinator was conducted on / / and he stated that all but 2 residents in the facility, who required home health services, were utilizing one third party provider for home health care (Third Party Provider).

A review of the Third Party Provider ' s resident list, dated / , indicated that 47 residents in the facility were receiving services from them. The census on the date of the visit was 79.

A review of the facility ' s admission package showed a document called, Home Health Care-Change/Discharge & Choice Letter. The letter references patient rights to choose a home health agency.

An interview with the resident care director was conducted on / at 11:24 AM and he stated that the choice letter is usually used when the resident changes companies. He stated that when the resident is admitted they are asked what home health company they want. He stated that there should be a signed letter in residents ' files.

An Interview was conducted with Resident #2 at 10:05 AM on / /. When asked how she chose the home health company, she stated that she had no idea and did not remember if she was given options.

Interviews were conducted with the responsible parties for Resident #3 and #1. Resident #3 and #1 reside in the facility ' s memory care unit.

An interview with Resident #3 ' s Power of Attorney (POA) was conducted on at 10:05 AM. When asked how he chose the home health company his mother uses, he stated that he didn ' t choose-

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the facility told him who they were going to use. He stated that they handle all that and, " ...it ' s all part of the deal. "

An interview with Resident #1 ' s POA was conducted on I/ at approximately 12:00 PM. Resident #1 ' s POA indicated that she did not choose a home health company. She stated that she was not aware of services being from a home health care company and had no communication from the company.

A review of the Third Party Provider ' s Admission Consent form, dated for Resident #1 showed a signature that does not belong to the resident ' s POAs or the resident. An additional form obtained from the Third Party Provider entitled, Continuity of Care Authorization Form, dated showed a patient signature that does not belong to Resident #1 ' s POAs or the resident.

A review of facility records for Residents #1, #2, and #3 showed that none of their files contained a Home Health Care- Change/Discharge & Choice Letter (Choice Letter) for home health care.

An interview was conducted with the resident care coordinator and administrator on I/ concerning the lack of Choice Letters in Resident #1, #2, and #3 ' s files. The resident care coordinator attempted to find the letters and at 1:00 PM stated that there were no letters to show.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
Summit At New Port Richey
5539 Charles Street
New Port Richey, FL 34653

RE: CCR #2015012324

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on [redacted], 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 [redacted], 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.

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,

for Patricia Reid Caufman
Field Office Manager

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