STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968543	12/31/2015
NAME OF PROVIDER OR SUPPLIER **NEW BEGINNING ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **418 NW 21ST TERRACE CAPE CORAL, FL 33993**	

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

0000 Initial Comments

A Monitoring Visit was completed on 12/31/15 at New Beginning Assisted Living, Inc., an Assisted Living Facility in Cape Coral, Florida.

The following is a description of the deficiencies found at the time of the visit.

0030 Resident Care - Rights & Facility Procedures

Based on observations and interview, the facility failed to treat each resident with dignity and respect during the morning meal on / for 1 (Resident #3) of 3 residents.

The findings included:

1. Observation of the morning meal on / revealed Residents #1 and #2 came to breakfast and were served, coffee or tea, cereal with milk and toast as per the menu. Resident #3 was lead to the table at 10:19 a.m. by the Administrator. The resident was seated at the dining and given a bowl of cereal with milk and a spoon. No liquid was served. Resident #3 was observed to feed herself the cereal. At one point the resident moved her spoon outside the bowl onto the placemat and continued to scoop air to her mouth. This continued for approximately 10 minutes until the administrator noticed and redirected her spoon back to the bowl.

At 10:50 a.m. Resident #1 asked the Administrator what Resident #3 was going to drink with her meal. The Administrator told Resident #1, that Resident #3's husband had told her the resident had liked coffee, but now she found it bitter and would no longer drink it. Resident #1 said tea is good for you and maybe she (Resident #3) would like tea. The Administrator poured 4 ounces of tea into a glass and carried it to Resident #3. Standing beside the resident she held the glass to the resident's mouth. Resident #3 drank from the glass. The Administrator removed the glass and went back to the kitchen. Resident #3 continued to finish her cereal. Seven minutes later the Administrator returned with the remaining tea and a glass of water. She stood beside the resident and again gave her a drink. Resident #3 took the glass and drank the remaining tea. She was then offered the water. As Resident #3 did not take the glass the Administrator continued to stand beside her and hold the glass for her to drink from. After another 25 minutes, the Administrator was heard to say, "I forgot your toast." At 11:30 a.m. she took 1 piece of toast to Resident #3 to eat.

2. At 11:35 p.m. the Administrator said she did not feed Resident #3 all her meal at one time as she would pour it all together in a bowl and mix it up. She said she did not sit with the resident to assist or redirect her with her meals, but offered each selection, one at a time.

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Class III

0053 Medication - Administration

Based on observation and interview, the Administrator, who is a nurse, failed to observe the resident consuming the medications when administered for 2 (Residents #1 and 2) of 3 residents. Also the Administrator failed to document as needed medications given to Resident #3.

The findings included:

1. Observation during the breakfast meal on / revealed the Administrator carried the medications to Resident #1 and popped the medications into a pill cup. She told her what the medications were for. She then left and the resident began separating her medications into two piles and had one pill left over. She then took all the medications one at a time.

The Administrator was observed giving Resident #2 her medications in a pill cup when delivering her breakfast. Again the Administrator left and did not observe Resident #2 consume her pills.

Interviews with Resident #2 and #1 on / at 10:15 a.m. at the breakfast table revealed the meals were good. They get there medications from the Administrator and they take them. They are usually brought in a pill cup.

2. Record review on / of the Medication Observation Record (MOR) for Resident #3 showed Clonopin 0.5 mg by mouth twice a day as needed. The MOR showed the medication was given once on / and twice on / / , / / , / , / / , and / / . The MOR shows the initials RC for all 11 medications.

On / at 11:00 a.m., the Administrator verified the resident is and cannot ask for her medications. She verified the initials RC belong to a former Certified Nurse Aide (CNA) who worked for her. She stated the CNA would call her when Resident #3 was agitated and she would come over and administer the medication. She did not answer when asked, why the CNA would document the medication being given on the MOR and not her, if she came to the facility and gave it.

Class III

0054 Medication - Records

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on record review and interview, the facility failed to document on the Medication Observation Record (MOR) as the medications were given for 3 (Residents #1, #2 and #3) of 3 residents.

The findings included:

1. On I/ , a review of the 2015 MOR for Resident #1 revealed no medications were documented given on I/ , I/ , I/ or I/ . The 8:00 p.m. medications were not documented as given on I/ . For 2015, no medications were documented on or .

2. On I/ , a review of the 2015 MOR for Resident #2 revealed no medications were documented giving on I/ . The a.m. medications were not documented on I/ .
40 mg was not documented at 5:00 p.m. on I/ , I/ , I/ or I/ / .
10 mg was not documented given at 8:00 p.m. on I/ , I/ , I/ and I/ .
40 mg was not documented given at 8:00 p.m. on I/ , I/ , I/ , and I/ .
25 mg was not documented given at 8:00 p.m. on I/ / , I/ , I/ / and I/ .
Gas Relief to be taken twice a day at 8:00 a.m. and 7:00 p.m. was not documented I/ , I/ , and I/ or I/ and not documented at 7:00 p.m. on I/ .
25 mg was not documented given at 8:00 p.m. on I/ / , I/ , I/ , and I/ / .
Lotemax , 0.5% to be given at 8:00 a.m. and 7:00 p.m. was not documented given on I/ / , I/ / , I/ / , I/ / or / and not document given at 7:00 p.m. on I/ /1, I/ , I/ / and I/ / .

For 2015, no medications were documented on or . Gas Relief to be taken twice a day at 8:00 a.m. and 7:00 p.m. was not documented since to .

3. On I/ , a review of the 2015 MOR for Resident #3 revealed no medications were documented given on I/ / , I/ / , I/ or I/ .
For 2015, no medications were documented on or .

4. On I/5 at 8:52 a.m. the Administrator, who is a nurse, said all medications are always given and asked if she could document the missing medications now.

Class III

0055 Medication - Storage and Disposal

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Based on observation, record review and interview, the facility failed to dispose of medications after residents left the facility for 3 residents.

The findings included:

1. On 12/31/15 the top drawer of the medication cart was observed to contain a bottle of Liquid Gels marked "Mary." Also suppositories 10 mg for Resident #4 and 0.4 mg for Resident #5.

2. On / at 8:52 a.m. the Administrator said the belonged to a respite resident who did not stay at the facility more than 24 hours and the other two medications were for former residents. The Administrator said she knew she was supposed to dispose of the medications, but had not.

3. A review of the admission and discharge log revealed no respite resident documented. It showed Resident #4 on and Resident #5 was admitted on with no discharge date.

Class III

0057 Medication - Over The Counter (OTC) Products

Based on observation and interview, the facility failed to ensure no stock medications were maintained in the facility.

The findings included:

1. On / the top drawer of the medication cart was observed to contain a bottle of Liquid Gels marked "Mary." Also suppositories 10 mg for Resident #4 and 0.4 mg for Resident #5.

Containers of with (prescription label removed), , Bauer 81 mg, Equate , 81 mg, Flintstone with iron, plus and 14 tablets were observed with no names or labels on them.

2. On / at 8:52 a.m., the Administrator said the Plus was hers. She said she knew she is to dispose of the medications after a residents leaves but had not. After a while the Administrator said the other over-the-counter medications were hers also.

Class III

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0093 Food Service - Dietary Standards

Based on observations and interviews, the facility failed to ensure menus were followed, posted and dated as used, and substitutions were documented before or when a meal is served and maintained for 6 months.

The findings included:

On / the Administrator provided a 4 cycle menu. The menus had no dates of when they were used. The Administrator said she did not date them as she used them. When asked which cycle she was on she did not know. She further said she had no documentation of any substitutions.

Observation of the facility found no posted menu, only a board propped on the counter with "Meal of the day, , Breakfast: toast/eggs/sausage; Lunch: steak and cheese sandwich; and Dinner: Soup and Sandwich" written on it.

Wednesday breakfast on all 4 cycles was waffles, margarine, syrup, juices and milk. The lunch meal was pork chops, roasted turkey, or Salisbury steak with a salad and starch and vegetable depending on the cycle of the menu. The lunch meal on Fridays was fish or seafood.

On / at 9:30 a.m., the Administrator said Christmas lunch was pork chops, green beans, stuffing, macaroni and cheese and a biscuit. Residents #2 said she was in the facility at Christmas for lunch and verified the meal was what the Administrator had said. Resident #1 had lunch out with her family.

Class III

0160 Records - Facility

Based on record review and interview, the facility failed to maintain an admission and discharge log with the name of each resident, date of admission, the facility or place from which the resident was admitted, and/or date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged for at least 4 known residents.

The findings include:

1. On / , the Admission and Discharge (A/D) log was reviewed. The last entry was with a last name. No place admitted from, date of discharge, reason for discharge or place discharged to, was

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listed.

Residents #1 and #2 were not listed on the A/D log. Further review revealed no resident named "Mary" was listed on the log.

2. On / at 9:15 a.m., the Administrator said "Mary" was a respite who came but did not stay after 1 day. She said Resident #5, admitted on , was no longer here. She was unsure of the exact date of his discharge. She verified Resident #1 was admitted on , but was not on the log. She further verified Resident #2 was admitted on / , and was not on the log.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
New Beginning Assisted Living, Inc
418 Nw 21st Terrace
Cape Coral, FL 33993

Dear Administrator:

This letter reports the findings of a state licensure monitoring survey that was conducted on , 2015 by a representative 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.

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 this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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