STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963901	08/25/2016
NAME OF PROVIDER OR SUPPLIER **JOHN-NELL MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **1012 GULF ROAD** **TARPON SPRINGS, FL 34689**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

On , 2016 a biennial re-licensure survey with limited mental health (LMH) was conducted at John-Nell Manor. Deficient practice was identified during the survey.

(License number 7977)

0052 Medication - Assistance with Self-Admin

Based on interview and record review, the facility failed to report suspected non-compliance with medications to the resident's health care provider for 1 (Resident #1) of 2 medication observation records reviewed.

Findings included:

A review of medication records was conducted on . A review of Resident #1 ' s medication observation records (MORs) showed the medication 8.6 MG Tablet- Take 1 Tablet by mouth once a day for . The MORs for this medication for the dates of / - showed the letter R. The second side of the MORs did not contain any explanations.

The administrator was interviewed at 1:30 PM on concerning Resident #1 ' s MORs and the 8.6 MG Tablet. The administrator stated that the resident refused the medication from / through . The administrator was asked if she had documentation concerning notifying Resident #1 ' s health care provider of the refusal of the medication and she stated that she had no proof of notification.

Class III

0054 Medication - Records

Based on observation, interview and record review, the facility failed to update medication observation records (MORs) immediately after a medication was offered or administered for 2 (Resident #1 and Resident #2) of 2 MORs reviewed. Additionally, the facility failed to maintain MORs with all medications listed with the name, strength, and directions for use of each medication for 1 (Resident #2) of 2 MORs reviewed.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963901	**08/25/2016**
NAME OF PROVIDER OR SUPPLIER **JOHN-NELL MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **1012 GULF ROAD TARPON SPRINGS, FL 34689**	

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

Findings included:

A review of facility medication records was conducted on . A review of Resident #1 ' s MORs showed the medications Maxim 1%- apply to face once a day for and 2% Shampoo- apply as directed on Monday, Friday for dermatological. The MORs also showed that the MORs were not updated from / through as to whether the medications were given.

The administrator was interviewed at 1:32 PM on concerning Resident #1 ' s MORs and assistance with self-administration of Maxim 1% and 2% Shampoo. The administrator stated that Resident #1 preferred to apply the Maxim 1% by herself but assisted the resident with application of the 2% Shampoo. The administrator also acknowledged that the MORs were not updated as to whether the medications were utilized.

A review of Resident #2 ' s medications showed / - MG Tabl (sic) - Take 1/2 tablet by mouth twice a day. A review of Resident #2 ' s MORs showed that the medication was not listed.

The administrator was interviewed at 1:56 PM on concerning the / - MG Tabl that was observed within a stack of Resident #2 ' s medication packages. The administrator acknowledged that the medication was not listed on the MORs and stated that the medication had been ordered by Resident #2 ' s health care provider on and the MORs had been printed for use as of / without updating them for this additional medication order.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2016

Administrator
John-Nell Manor
1012 Gulf Road
Tarpon Springs, FL 34689

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited mental health (LMH) that was conducted on [redacted], 2016 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], 2016.** 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

PRC/clt
Enclosure: State (5000-3547) Form

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida