STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966320	**06/23/2017**
NAME OF PROVIDER OR SUPPLIER **NEW ERA ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **815 WEST DAUGHTERY RD** **LAKELAND, FL 33809**	

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

0000 - Initial Comments

Assisted Living Facility

A biennial state licensure survey with limited nursing services (LNS) and limited mental health (LMH) was conducted at New Era Assisted Living on , 2017. Deficiencies were identified at the time of the visit.

(license# 10535)

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to ensure an interdisciplinary care plan ( ), specifying those care and services provided by Hospice and those care and services provided by the facility and agreed upon by Hospice, the Facility, and the Resident (or Resident's representative) was developed and implemented for one Hospice Resident (#2) one sampled Hospice Resident.

Findings included:

A record review conducted on for Hospice Resident #2, revealed that the Team Care Plan in the resident's chart was a Hospice Team Care Plan (Photographic Evidence 4 obtained) and was not an Interdisciplinary Care Plan between Hospice and the Facility. This Team Care Plan did not specify those care and service provided by Hospice and those care and services provided by the Facility. There was no indication that this Hospice Team Care Plan was agreed upon by Hospice, the Facility, and Resident #2.

In an interview conducted on at 11:55 am the Administrator stated, "We don't have anything like that. We just have the one from Hospice. I'll create one." The Administrator agreed to call Hospice when surveyor explained that the Interdisciplinary Care Plan is to determine the coordination and communication of resident care and the agreeance to the specific resident care by all parties involved the resident's care.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966320	06/23/2017
NAME OF PROVIDER OR SUPPLIER **NEW ERA ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **815 WEST DAUGHTERY RD** **LAKELAND, FL 33809**	

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

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview, the facility failed to honor Resident rights by failing to ensure a safe and hazard-free living environment for three Residents (#5, #6, and #9) of four sampled Residents who use portable tanks.

Findings included:

An observation on at 10:20 am discovered two larger and two smaller portable tanks in a box and one freestanding portable tank stored in resident's (#6) closet (Photographic Evidence 1 obtained).

An observation on at 10:22 am discovered six freestanding portable tanks near the head of resident's (#5) bed (Photographic Evidence 2 obtained). The Assistant Administrator stated that the company would be called to have storage racks delivered.

An observation on at 12:38pm discovered seven freestanding smaller portable tanks and one properly secured larger portable tank at resident's (#9) bedside (Photographic Evidence 3 obtained).

An interview conducted on at 12:45pm with the Administrator confirmed that the facility does not have a policy and procedure on safe portable storage and is unable to describe safe storage of portable tanks. The Administrator stated that the company had been called for the delivery of storage racks. No storage racks delivered before the end of survey at 03:30pm

The National Fire and Protection Association (NFPA) and Occupational Safety and Health Administration standard for safe cylinder storage is that "all freestanding cylinders must be stored in a rack, a cart, or another enclosure to protect them. Unsecured cylinders could , breaking the valve and possibly resulting in a rapid release of the gas, propelling the cylinder and turning it into a dangerous projectile."
Refer to the Fire Marshall

Class III