STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910790	**05/10/2018**
NAME OF PROVIDER OR SUPPLIER **NEW PORT RITCHEY CENTER FOR ASSISTED LIVING AND ME**	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

On , , 2018, a Change of Ownership (CHOW) Provisional Licensure for the period to was conducted at New Port Richey Center for Assisted Living and Memory Care (formerly known as Summit at New Port Richey). Deficient practice was identified during the survey.

(License #5421)

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

Based on record review and interview, the facility failed to develop and implement an interdisciplinary care plan between hospice and the facility for five (Residents #2, #12, #20, #21, and #22) of five residents receiving hospice services.

Findings included:

A record review conducted on revealed there was no interdisciplinary care plan between hospice and the facility for Resident #2.

An interview was conducted on at 1:34 PM with the Wellness Director. The Wellness Director acknowledged and confirmed that the facility did not have an interdisciplinary care plan between hospice and the facility for Residents #2, #12, #20, #21, and #22, all of whom were admitted to hospice services.

During the exit conference on at 4:17 PM, the Administrator acknowledged and confirmed that the facility did not have an interdisciplinary care plan between hospice and the facility for any of the facility's residents that receive hospice services.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, interview, and record review, the facility failed to substitute menu items with foods of comparable nutritional value and document the menu substitution log before or during the meal. Additionally, the facility failed to ensure that therapeutic diets were prepared and served as ordered by residents' health care providers.

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Findings included:

A dining and food service review was conducted on . . . . . The posted lunch menu stated cheese ravioli, eggplant parm (sic), garlic bread, vegetable medley, fruit salad, and milk or hot beverage. An observation of the lunch meal at 12:00 PM showed that this was the meal served to residents.
A review of the registered dietitian approved menu for the day's lunch meal was beef pepper steak, scalloped potatoes, seasoned buttered corn, baked fruit pie, rye bread with margarine (photographic evidence obtained). A review of the menu substitution log after the meal showed the last note dated . . . . (photographic evidence obtained).

A series of interviews began with the Dietary Director at 12:44 PM on . . . . . The Dietary Director stated that they "mix and match" the menu, move stuff around, and were not really sticking to the menu. They acknowledged that they did not note the lunch meal substitutions on the menu substitution log before or during the meal. They also acknowledged the substitution of eggplant parmesan for the beef pepper steak was not of comparable nutritional value for protein.

During observation of the noon meal on at 11:50 AM in the memory care unit, it was revealed that two residents #15, #16, did not receive the therapeutic diet as ordered by their health care provider.

A review of resident #15's health assessment showed the resident was receiving kidney , twice a week and was placed on a . . diet on . . . . . by the health care provider. Further review revealed dietary orders dated from the , group that the resident had been going to for treatment.

Resident #16 started yelling in the memory care dining they were still hungry and wanted a second lunch plate. One of the staff stated they could have some fruit but that they could not provide a second helping because it was pasta and it would make the resident's sugar go up too high. The resident yelled until they received a second serving of pasta. The staff stated that the resident gets out of control if they don't comply with the resident's wishes.

A review of the Resident#16's health assessment revealed that the resident was to receive a Diet.

An interview was conducted with the Dietary Director on . . . at 2:00 PM. The dietary director stated that a diet is a carb controlled diet. The resident did not receive a carb controlled diet for the lunch meal observed.

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The cook did not have a carb diet or a diet available for review. The facility was not able to comply with either of the therapeutic diets.

The Director of Resident Care stated that Resident #16 would not comply with a therapeutic diet. The facility did not have documentation of the resident's refusal to comply with the diet and did not have documentation that they had notified the physician or responsible party.

Class III