STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965496	01/27/2014
NAME OF PROVIDER OR SUPPLIER **Horizon Bay Vibrant Ret Living 450**	STREET ADDRESS, CITY, STATE, ZIP CODE **7650 University Drive Tamarac, FL 33321**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments
Unannounced complaint inspection surveys (CCR# 2013011469 and #2013010009) were conducted on [redacted] at Horizon Bay Vibrant Retirement Living 450. The facility had deficiencies found at the time of the visit.

Deficient practice identified at CCR#2013010009.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on observation, interview and record review, the facility failed to comply with the continued admission criteria. As evidenced by the failure of the facility to maintain an accurate Health Assessment form,completed upon significant change and reflective of the resident's current health status and increasing care needs, for 3 of 3 sampled residents (Resident #2, #3 and #4).

The findings include:

1. Resident #2 was admitted on [redacted] with medical diagnosis of [redacted] Prostatic Hyperplasia [redacted] and unsteady gait. Review of the current 1823 Resident Health Assessment dated [redacted] reveals the resident has no nursing, treatment requirements documented on the form. He is independent for ambulation via walker, transfers and eating. He requires assistance with bathing, dressing, self- care and toileting. The resident is assessed to require daily observation of well-being, whereabouts and reminders for important tasks. The resident requires assistance with self-administration of medications by the facility.

Review of the Nurses Note dated [redacted] reveals the resident was admitted with an indwelling [redacted] Review of the Health Assessment 1823 form dated [redacted] reveals the resident has no [redacted] but requires assistance with his ADL care.

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Review of the resident Personal Service Plan was dated reveals the resident is oriented to person, place and time. He has a diagnosis of and takes 7 or more medications including medications. He is able to communicate his needs and preferences. He requires the staff attention for prompts with dressing and and requires physical assistance with putting on and taking off clothing. The resident is documented as able to perform showering tasks with physical assistance as needed. He requires for incontinence of The resident is mobile via a walker and wheelchair. Review of the Physician Order dated reveals the resident is " Ok to do self- care for "

Review of the Psychiatrist note dated reveals the resident would not allow staff into his he was irritable and had He is documented as oriented to person and place. The physician orders medication changes, the to be increased and adds at bedtime, secondary to and agitation.

Review of the Psychiatrist note dated reveals the resident has schizo-effective, he is taking 2.5 mg at bedtime,] 4 mg twice a day, 500 mg in AM and 1000 mg at PM and 15 mg at bedtime. The note documents a good effect with

Review of the Medication Observation Record for 2014 reveals the resident is ordered 500 mg every AM and 1000 mg every PM; 2.5 mg at bedtime; 4 mg twice daily and 15 mg at bedtime.

On at approximately 11:30AM during an interview with the Med Tech, she stated that she has worked at the facility for 3 years and the resident has always had an indwelling She stated that the resident goes monthly to the urologist to have the changed. She stated that the resident is scheduled to see the urologist on She stated that the aides do not provide care for the resident, they only empty the drainage bag. She stated that the resident sometimes will care for the himself and sometimes he does not. She stated that the resident was exhibiting changes in behavior in 2013 and had medications adjusted by the physician due to his negative behaviors toward staff and not performing ADL care. She stated that she is not aware of any nursing assessment being completed for the

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On at approximately 10:30AM during an interview with an aide, she stated that she does not provide or assist with care for the resident, she only empties the drainage bag. She stated that the resident takes a shower but she has never witnessed him performing care.

On at approximately 2:30 PM during an interview with an aide, she stated that she assists resident with showers but does provide or assist with care ever. She stated that she only empties the drainage bag. She stated that the resident does not clean the

On at approximately 12:30 PM during an interview with the LPN Wellness Care Director, she stated that the resident goes to the Urologist monthly for changes. She stated that there is no nursing documentation of any observations of the function of the resident. It was also revealed that she does not perform care.

On at approximately 12:45 PM during an interview with the Administrator she stated that she was unaware the resident was caring for his own She stated that she thought a Home Health Nurse was coming to the facility to monitor the She stated that since the resident had had a change in his mental condition and his medications were adjusted the Primary Care Physician should reevaluate the resident for his ability for self- care of the

2. Resident #3 was admitted to the facility on with , history of , history of electrolyte and fluid and lower extremity The 1823 Resident Health Assessment form dated reveals the resident to be alert and oriented to person and place with forgetfulness. He is ambulatory with a rolling walker. The nursing treatments required are documented as nursing to assist with ADL care and medication management. He requires supervision with ambulation for precautions and transfers, also with self care. He requires assistance with bathing, dressing and toileting. The form documents the resident has

Review of the Case Profile dated reveals the resident has an indwelling he is able to perform showering tasks with physical assistance as needed, uses a walker as mobility aid and he is not always oriented to time.

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Review of the 1823 Resident Health Assessment form dated reveals the physician has not seen the resident since but the assessment form is completed. The form documents the resident needs assistance with all ADL care. There is no documentation of a noted.

Review of the facility Personal Service Plan for the resident dated reveals the resident has an indwelling and staff are to assist with peri-care, care and emptying the drainage bag as needed. The form documents the resident has physical and is at risk for . He is not always oriented to time but can communicate his needs and preferences. Review of a Physician Order dated reveals the resident is " Ok to do self -care for ".

Record review of the Nurses Note dated reveals the resident is observed with in his and he is transferred to the hospital for evaluation. The physician and family are notified. The resident returns to the facility after the is changed and has a follow-up appointment made for .

On at approximately 10:00 AM, the surveyor along with the Wellness Care Director, entered the resident's . The resident was observed sitting in his recliner chair with his legs elevated, both lower extremities were edematous and the skin on the lower legs was reddened and shiny. A drainage bag was observed attached to the wheel chair, placed next to the recliner. The tubing was exposed from under the resident shorts. When questioned by the surveyor, as to what the tubing was for, the resident reached down and stated " I do not know what that is ". When questioned how the tube is cleaned and personal care is performed, resident looked and did not answer.

The Wellness Care Director stated that the resident had been performing his own care daily and staff were only assisting with emptying the drainage bag. She stated that the resident goes to the urologist monthly for changes and that the facility staff do not monitor the . She agreed that the resident was and she questioned if he was appropriately caring for the by himself.

On at approximately 11:45 AM during an interview with the Wellness Care Director, she stated that the resident had been admitted with the ability to care for his own but based on the observation today she would recommend the physician re-evaluate the residents ability for

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self- care. She reviewed the current 1823 form dated and confirmed there was no documentation of the and care requirements noted. She stated she would arrange for the physician to reevaluate the resident for daily home health care for the She stated that the facility has nurses on staff but they did not perform any care for the resident.

On at approximately 1:00 PM during an interview with the Administrator, she confirmed that the facility does not have an Limited Nursing Service license. She was informed of the resident observation by the surveyor and Wellness Care Director. She stated that she was not aware that the resident was caring for his own , she thought a Home Health Nurse was visiting the resident. She stated that the facility staff have not been providing the additional monitoring, and care required for use. She stated that the resident should be reassessed by the physician for a change in condition and the 1823 should be corrected to accurately reflect the residents current condition.

3. Resident #4 was admitted on with medical diagnosis of A-fibri , , generalized pain, hip replacement and . Review of the 1823 Health Assessment form dated reveals resident is alert to name only. She is mobile by wheelchair only. She requires assistance with all ADL care and documented as needing assistance with self- administration of medications.

Review of the Hospice Admission Evaluation dated reveals the resident was admitted for and Failure. She is documented as of bowel and and requires total ADL care. She has and is feed a mechanical soft diet. She has mobility and requires frequent naps throughout the day.

The 1823 Resident Health Assessment form was not updated to reflect a change in condition for the resident and admission to hospice services on The resident is being administered medications by unlicensed staff , the medications including , , patches, and .

The Hospice Note dated reveals the resident is oriented to self only, she is bed bound/ chair bound, able to speech only limited words and sleeps throughout the day.

On at approximately 10:45 AM, the resident was observed by the surveyor and Wellness Care Director, in her in a wheelchair. The resident was asleep and the private aide stated that she sleeps a lot during the day. The aide stated that the resident only speaks a few words

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occasionally. The resident awakened with verbal stimulation, opened her eyes but did not respond verbally to the surveyor or Wellness Care Director. The Wellness Care Director stated that the resident was on hospice services but the facility Med Tech was providing the medications for the resident. When questioned if the resident would be considered and unable to express the names of medications, time of administration or purposes for the medications, the Wellness Care Director stated the resident is oriented to name only. She stated that the resident only responds with a few words occasionally. She agreed that the resident should be not be documented as able to self administer her own medications. Therefore she should be administered the medications by a licensed nurse who would assess and monitor the resident.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Horizon Bay Vibrant Ret Living 450
7650 University Drive
Tamarac, FL 33321

RE: CCR #2013010009 & CCR #2013011469

Dear Administrator:

This letter reports the findings of complaint surveys that was conducted on , 2014 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. Staff from this office will conduct a review after **, 2014** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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