STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966265	06/09/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
A New Horizon Manor	7968 W 14 Court Hialeah, FL 33014	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0051 - 58a-5.0185(2) Fac - Medication - Pill Organizers S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0057 - 58a-5.0185(8) Fac - Medication - Over The Counter (otc) Products S-S= D
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - L241 - 58a-5.029(2) Fac - Lmh - Records S-S= A

Specific Tag Findings:

0000-Initial Comments

A Standard Biennial Re-Licensure Survey was conducted at A New Horizon Manor on . . . . . At the time of the survey, deficiencies were identified.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on observation, record review, and interview the assisted living facility failed to ensure 4 out of 6 (resident #1, resident #2, resident #3, and resident #5) current residents had a accurate and completed health assessment {AHCA Form 1823}.

Findings Include:

1) Observations on . . . . . at approximately 12:00 PM found staff B assist resident #1 with self-administration of medication.

2) Record review of resident #1's record revealed she was admitted to the facility on . . . . . Record review found a health assessment dated . . . . . which indicated resident required medication administration. Record review found a health assessment dated . . . . . which just indicated resident #1 required help with medications but what type of help was not identified (assistance with self-administration of medication or administration of medication).

Record review of resident #2's record revealed she was admitted to the facility on . . . . . Record review found a health assessment dated . . . . . in which the medication portion was left blank {not completed}. Record review found the type of assistance resident #2 required for medications are unknown.

Record review of resident #3's file revealed that health assessment (AHCA form 1823) completed on . . . . . indicated that resident #3 needs assistance with self-administration of medication. It did not indicate if resident #3's needs can be met in an assisted living facility.

Record review of resident #5 's file revealed that health assessment (AHCA form 1823) completed on . . . . .

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indicated that resident #5 needs assistance with self-administration of medication.

3) In an interview with caregiver_B on at 8:45 a.m. revealed that she crushed resident #3's medicines, mixed them with milk or apple sauce and administered the mixed inside resident #3 mouth with a spoon. She confirmed that she was not a licensed practical nurse or a registered nurse.

In an interview with resident #1 on at approximately 9:30 AM, she stated she gets her medications in a little cup at the table while she is eating. She stated the staff do not tell her what she is taking.

In an interview with administrator on at 9:30 a.m. revealed that resident #5 received administration with a home health agency.

In an interview with caregiver_B on at 9:54 a.m. revealed that she assumed that resident #3 needed medication to be crushed.

In an interview with resident #2 on at approximately 9:53 AM, she stated the staff bring her medication with a glass of water every time she needs to take them.

In an interview with the owner on at approximately 1:10 PM, she acknowledged the findings.

Class III

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

Based on observation and interview the assisted living facility failed to ensure that 6 out of 6 (resident #1- #6) current residents were living in a safe and descent living environment and treated with consideration and respect and with the need for privacy. The facility failed to follow resident's physician order to use full bed rails as well as to have a resident's consent to the use of full bed rails for one out of six sampled residents (resident #3).

Findings Include:

1) Observations during the course of the survey from approximately 8:05 AM to approximately 1:30 PM found residents would go outside and would have to go through the living to get to the sliding door to access the patio.

Observations during the initial tour of the facility on at approximately 8:10 AM found a day bed located in the living Observations also found a television located in the living

In an interview with staff B on at approximately 8:45 AM, she stated she works at the facility for 24-hour shifts. She stated she sleeps on the futon {day bed} located in the common area where the residents go to watch television.

In an interview with resident #1 on at approximately 9;30 AM, she stated the staff sleep on the day bed in the living "the other are taken". She stated she does not use the area to watch television but other residents do.

In an interview with the owner on at approximately 1:10 PM, she acknowledged the findings and stated she was going to make sure she finds another place for the staff to sleep.

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2) Observation on at approximately 8:07 a.m. revealed that resident #3 was resting on bed in with two half-bed rails up.

Record review for resident #3's file revealed that there was a doctor order for the use of full bed rail dated and signed There was no consent to the use of full bed rails.

In an interview with administrator on at approximately 9:25 a.m. revealed that she could not find the consent for the use of full-bed rail for resident #3.

Class III

0051-Medication - Pill Organizers 58A-5.0185(2) FAC

Based on observations, record review, and interviews the assisted living facility failed to ensure pill organizers were managed by a nurse and that only resident who self-administered medications used the pill organizers.

Findings Include:

1) Observations during the initial tour of the facility on at approximately 8:15 AM found pill organizers located with the centrally stored medication which belonged to resident #4 and resident #6. Observations found resident #4 and resident #6 did not have any other medications other than that was located in the pill organizers.

2) Record review found medication observation records {MORs} for both resident #4 and resident #6 in which unlicensed staff were signing off as they assisted both resident #4 and resident #6 with their medications.

Medication reconciliation for resident #4 revealed: 300 mg, take one capsule every morning and 2 capsules every night at bedtime; 100 mg, take one tablet every day at noon and 3 tablets every night at bed time; 20 mg tablets take one tablet by mouth once a day; low 81 mg, take one tablet every day; ER 100 mg tablet, take one tablet by mouth twice a day; 12.5 mg capsules, take one capsule by mouth once a day; 850 mg tablets, take one tablet by mouth twice a day; 10 mg tablets take one tablet by mouth once a day; 150 mg tablets take one tablet by mouth twice a day and 325 mg tablets, take one tablet by mouth twice daily.

Medication reconciliation for resident #6 revealed: 100mg tablets, take one tablet every morning and take 3 tablets every night at bedtime; 0.05 mg tablet, take one tablet by mouth once a day; 15 mg tablets take one tablet by mouth at bedtime; low 81 mg, take one tablet every day; 20 mg tablets take one tablet by mouth once a day; Doc-Q-Lace 100 mg capsules, take one capsule by mouth twice a day; 20 mg capsules, ayke one capsule by mouth once a day; 325 mg tablets, take one tablet by mouth twice daily; 5 mg tablets take one tablet by mouth once a day and 20 mg tablets take one tablet by mouth once a day.

3) In an interviewed with caregiver_B on at approximately 8:19 a.m. revealed that residents #4 and #6 were admitted to facility on Saturday and they came with pill organizer. Residents #4 and #6's sister prepared pill organizers but she assisted resident #4 and #6 with medication self-administration. At the time of medicines she took medicines out of pill organizers, placed them on a cup, handled to resident and signed medication

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observation record. She was not a licensed practical nurse or registered nurse.

In an interview with resident #6 on at approximately 11:00 AM, she stated the only assistance she gets from the staff is with her medications. She stated she receives her medications in a cup. She stated she receives her medications "in the type of cups they have in the hospital".

In an interview with the sister of both resident #4 and resident #6 on at approximately 11:30 AM, she stated that she prepared the pill organizers for both resident #4 and resident #6.

In an interview with the owner on at approximately 1:10 PM, she acknowledged the findings.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

Based on observations, record review, and interview the assisted living facility failed to keep all prescription medications and over the counter (OTC) products locked up at all times. The facility failed to ensure resident medications were disposed of in a timely manner for discharged residents. The facility failed to ensure expired medications be disposed of within 30 days.

Findings Include:

1) Observations during the initial tour of the facility on at approximately 8:05 AM found multiple OTC products including and throat spray on the night stand located in Observations found the door to was opened and remained opened during the course of the survey. Observations found resident #1 resided in Observations found two beds located in

Observations during the initial tour of the facility on at approximately 8:15 AM, found expired medications located in the medication refrigerator. Observations found the expired medications belonged to both current and former residents. Observations found the following medications:

- Promrthegan 25 mg (milligram) supp.(prescribed to resident #7). Expired

- Promrthazine 25 mg (prescribed to resident #7). Expired

- 650 mg supp. (prescribed to resident #3). Expired

2) Record review of the facility's admission and discharge log revealed resident #7 was discharged from the facility on Record review found resident #3 was admitted to the facility on and is a current resident.

Record review of resident #1's record revealed she was admitted to the facility on Record review found a health assessment dated which indicated resident required medication administration.

3) In an interview with the owner on at approximately 1:10 PM, she acknowledged the findings and stated that resident #1, who resides in usually keeps those medications in her draw. She stated that she forgot to discard the medications in the refrigerator.

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Class III

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC

Based on observation and interview the assisted living facility failed to ensure all Over the Counter (OTC) Products were properly labeled as required by 58A-0185(8)(b).

Findings Include:

1) Observations during the initial tour of the facility on . . . . . at approximately 8:05 AM found multiple OTC products including . . . . and . . . . throat spray on the night stand located in . . . . Observations found that two . . . . . bottles and the . . . throat spray did not have a residents' name on it and only had the manufacturers' label.

2) In an interview with the owner on . . . . . at approximately 1:10 PM, she acknowledged the findings and stated that resident #1, who resides in . . . . . , usually keeps those medications in her draw.

Class III

0077-Staffing Standards - Administrators 58A-5.019(1) FAC

Based on observation, record review, and interview the assisted living facility failed to notify the Agency Central Office within 10 days of a change in facility administrator. The facility failed to ensure the assistant administrator (manager) completed the CORE training requirements.

Findings Include:

1) Observations on . . . . . at approximately 8:00 AM found staff A and the manager at the facility upon entrance.

Observations on . . . . . at approximately 9:00 AM found the owner arrived to the facility.

2) In an interview with staff B on . . . . . at approximately 8:00 AM, she stated the administrator is not at the facility. She stated she would call the administrator to come to the facility.

In an interview with the owner on . . . . . at approximately 9:00 AM, she stated she is the administrator of the facility. She stated she sent a change of administrator request form to the Agency. She stated she is the owner of three assisted living facilities but is only the administrator of two of them.

In an interview with the owner on . . . . . at approximately 9:15 AM, she stated the administrator is now the administrator of one of her other facilities. She stated it was closer for her to be the administrator there. She stated it was hard for the administrator to come here so they switched. She stated they did the change in . . . . of 2013. She stated she sent it by mail to the Agency. She confirmed she is the administrator of two other facilities. She confirmed her manager. She stated her manager is CORE trained but could not pass the CORE exam. She stated she has been the manager at the facility for 18 years. She stated her husband also helps her and took the CORE training but also could not pass the exam.

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In an interview with the owner on at approximately 9:22 AM, she confirmed that the administrator is not the manager. She confirmed who the manager was. She stated she never knew the manager needed to be CORE trained. She stated she is only the administrator of three facilities. She stated the last time the administrator was at the facility was in of 2013. She stated she remembers the date very well because the last time she was here was during an Agency inspection in

In an interview with the manager on at approximately 10:21 AM, she confirmed she is the manager of the facility. She stated the owner comes to the facility about every other day.

3) Record review of the manager's personnel record revealed she was hired on Record review revealed the manager completed the CORE training hours on Record review lacked any evidence that the manager completed and passed the CORE exam.

Website review of floridahealthfinders.gov revealed the administrator was still listed at the administrator on

In email correspondence with the Assisted Living Unit on at approximately 9:11 AM, they confirmed that they have received no change of administrator form for the facility.

In email correspondence with the Assisted Living Unit on at approximately 10:16 AM, they indicated that the owner is currently the administrator of three assisted living facilities (not including this facility).

In an interview with the owner on at approximately 1:10 PM, she acknowledged the findings.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC

Based on observation, record review, and interview the assisted living facility failed to maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period.

Findings Include:

1) Observations on at approximately 8:00 AM found only staff A and the manager at the facility upon entrance.

2) Record review of the facility staffing schedule for to found for Monday staff A and staff B were scheduled to be at the facility from 8 AM until 8 PM and the administrator was scheduled to be at the facility from 3:00 PM until 7:00 PM. Record review found the administrator was still listed on the staffing schedule.

3) In an interview with the owner on at approximately 9:22 AM, she stated the last time the administrator was at the facility was in of 2013. She stated she remembers the date very well because the last time she was here was during an Agency inspection in

In an interview with the owner on at approximately 1:10 PM, she acknowledged the findings and stated she needs to update her schedule.

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Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on record review and interview the assisted living facility failed to ensure 1 out of 3 (staff A) sampled employees had a minimum of 2 hours of continuing education training on providing assistance with self administration medication annually.

Findings include:

1) Personnel record review of staff A's file revealed she was hired on . . . . . Record review on . . . . . found staff A completed her last two hour assistance with self-administration of medication training update on . . . . .

Record review of resident medication observation records (MORs) confirmed that staff A has been providing assistance with self-administration of medication as recent as . . . . . .

2) In an interview with the owner on . . . . . at approximately 12:20 PM, she stated staff A gives out medications to the residents when she is working. She stated she has completed the trainings. After looking at the training date on the certificate, she stated that staff A went to Cuba for a couple of weeks but is back now. She confirmed staff A's training needed to be updated.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observation and interview the assisted living facility failed to provide a safe living environment, free of hazards, and ensure that all ceilings and fans located in . designed for resident use was in good repair.

Findings Include:

1) Observations during the initial tour of the facility on . . . . . at approximately 8:05 AM found multiple areas of the ceiling had stain-like substances in , and the living . . . Observations found resident #1 resided in . . . and resident #2 resided in . . Observations also found the fan located in . . . . . appeared to be covered in a dust-like substance.

2) In an interview with resident #1 on . . . . . at approximately 8:10 AM, she stated that the stains started coming onto the ceiling about 15 days ago when it was raining a lot.

In an interview with staff B on at approximately 8:12 AM, she confirmed that is happened after it rained approximately 15 days ago.

In an interview with the owner on . . . . at approximately 1:10 PM, she acknowledged the findings and stated that her husband was supposed to fix the leak but he has not gotten to it as of yet. She stated she will make sure it will get fixed before the follow up occurs.

Class III

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0162-Records - Resident 58A-5.024(3) FAC

Based on interview and record review the Assisted Living Facility failed to have a health care provider's order for nursing services for one out of six sampled residents (#5).

Findings include:

1. In an interview with caregiver_B on at approximately 8:10 a.m. revealed that resident #5 received administration by a nurse from a home health agency.
In an interview with administrator on at 9:30 a.m. revealed that resident #5 received administration with a home health agency.

2. Record review for resident's #5 record revealed that there was not doctor order for the use of

Class III

L241-LMH - Records 58A-5.029(2) FAC

Based on record review and interview, the assisted living facility failed to clearly identify mental health residents on the admission and discharge log.

Findings Include:

1) Record review of the facility's admission and discharge log revealed all residents were located on one admission and discharge log. Record review found resident #1 was admitted on resident #2 was admitted on , and resident #5 was admitted on Record review found no indication of the admission and discharge log that resident #1, resident #2, and resident #3 were limited mental health residents. Record review of one of the admission and discharge log pages revealed the special notes column was for documentation about the condition of the resident including pressure sores and limited mental health residents.

2) In an interview with the owner on at approximately 11:30 AM, she identified resident #1, resident #2, and resident #5 as limited mental health residents. She stated none of the other residents are limited mental health.

In an interview with the owner on at approximately 1:10 PM, she acknowledged the findings.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
A New Horizon Manor
7968 W 14 Court
Hialeah, FL 33014

Dear Administrator:

This letter reports the findings of a state standard biennial licensure survey that was conducted on , 2014 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.

Staff from this office will conduct a review after 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 surveyor(s). Should you have any questions please call Kristal Branton at 305-593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMI
Enclosure
XG90

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