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| NAME OF PROVIDER OR SUPPLIER<br>**HORIZON BAY VIBRANT RET LIVING 450** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**7650 UNIVERSITY DRIVE**<br>**TAMARAC, FL 33321** | |

SUMMARY STATEMENT OF DEFICIENCIES
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**0000 - Initial Comments**

An unannounced Relicensure Survey was conducted on - and and at Horizon Bay Vibrant Ret Living 450, license # 9889. The facility had deficiencies at the time of the visit.

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

Based on observation, record review and interviews, the facility failed to monitor the continued appropriateness of residency in this assisted living facility (ALF), for 1 out of 10 sampled residents (Resident #8).

The findings included:

A review of Resident #8's record was conducted on and revealed an AHCA Form 3008 which was signed by the physician and dated on . Section Y documents that the physician certification is checked off, as the individual requires nursing facility (NF) services. Section R indicates physical 3x a week. This form was faxed to the facility on , 2017 when Resident #8 was admitted.

A further record review was conducted of resident #8's health assessment (AHCA Form 1823) dated which showed an admission date to the facility on . The resident is 92yrs. old and his height is 5'8" and weight is 153 lbs. with a diagnoses of ( ), PAF ( ) and ( ). Resident #8's cognition and behavioral status were listed as , and his Physical or Sensory limitations were documented as "generalized physical and mental". Nursing/treatment/ service required, were documented as "None" and Special Precautions are recorded as "None". All ADL's (activities of daily living) on page 2 indicated the resident required "assistance". The assessment documented "no pressure sores" under the pressure inquiry. On page 3 of the 1823, it is blank under Section B "Does the individual need help with taking his/her medication" as well as indicating what type of assistance. On Page 5 the facility's DON (Director of Nursing) recorded "see care plan", which was not contained Resident #8's record.

Resident #8 had 6 documented from - and a hospitalization from - . The resident was not re-assessed to address the significant change and there was no evidence of an updated 1823 to reflect the current health status and needs of the resident. Resident #8's record did not contain any interventions, evaluations, prevention programs, or any referrals for services to provide continued residency.

An interview with Resident #8 on at 2:16pm was conducted and stated that he has had many

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recently and went to the hospital. During the observation, it was noted that the resident wore a call bell pendent around his neck. Resident #8 stated that he presses the button after he which typically occur during transferring to the toilet or bed. The resident stated that he had a private aid but it cost too much and didn't have it anymore. He had lived by himself prior to the admission to the facility and stated that part of the reason he was moving to the facility was because of his . Resident #8 stated that the staff told him that he is too big for them to lift up after a and instructed to call 911. His son who lives in NY is the POA power of attorney was notified on all these and said that his son yelled at him because he keeps falling. The resident was in a wheelchair and stated that he was told by the facility's DON to use it instead of his walker because he was not steady on his feet. Inquired about any other services such as physical , , or home health aide to assist and the resident responded that he thinks he will be getting some physical , , soon but did not know when. Observation of grab bars in the the toilet and a urinal by the bedside. The resident stated that he was told to use the urinal so he won't have to get up and that the staff comes in and empties it.

A further review of the facility's logs, post investigations and progress notes revealed that the facility did not implement a intervention for supervision and continued residency.

During an interview with the Administrator and the DON on at 5:45pm the findings was acknowledged and confirmed.

Class II

**0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC**

Based on observation, record review and interview, the facility failed to ensure appropriate supervision and interventions were implemented to prevent as stated in the facility's policy and procedure practices regarding a resident with a history, for 1 out of 10 resident records reviewed ( Resident #8). This is evident in the facility failure to implement interventions and care plans for Resident #8 after numerous within a two week period to prevent reoccurrence.

The findings included:

On a record review was conducted of resident #8's health assessment (AHCA Form 1823) dated which showed an admission date to the facility on . The resident is 92yrs. old and his height is 5'8"and weight is 153 lbs. with a diagnoses of ( , , ), PAF ( , ) and ( ). Resident #8's cognition and behavioral status were

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listed as , and his Physical or Sensory limitations were documented as "generalized physical and mental". Nursing/treatment/ , , service required, were documented as "None" and Special Precautions are recorded as "None". All ADL's (activities of daily living) on page 2 indicated the resident required "assistance". The assessment documented "no pressure sores" under the pressure inquiry. On page 3 of the 1823, it is blank under Section B "Does the individual need help with taking his/her medication" as well as indicating what type of assistance. On Page 5, the facility's DON (Director of Nursing) recorded "see care plan", which was not contained in Resident #8's record. Resident #8 was admitted to the facility on and sustained 6 and a hospitalization from - and the facility failed to conduct a Risk Evaluation, Complete a Post Assessment and identify approaches to implement, and document completely an Incident/Accident Investigation Report. Resident #8's record did not contain any interventions, program, evaluations or Personal Service Plan.

Resident #8 had 6 documented from - and a hospitalization from - . The resident was not re-assessed to address the significant change and there was no evidence of an updated AHCA form 1823 to reflect the current health status and needs of the resident. Resident #8's record did not contain any interventions, evaluations, prevention programs, or any referrals for services to provide continued residency. A review of the facility's Incident Reports and Post Investigations for Resident #8 revealed that the reports were incomplete and there was no Service Plan and/or Intervention addressing the supervision to maintain a safe environment for the resident.

An observation of Resident #8 was conducted during an interview on at 2:16pm where he stated that he has had several in the past few days and a hospitalization. It was observed that the resident was wearing a call bell pendant around his neck to use if he needs assistance. An observation of the resident's equipped with grab bars around the toilet. He was instructed by the facility's DON to us the wheelchair not his walker because he was not steady.

During an interview with the DON and the Administrator on at 5:45pm there was not a plan except for frequent checks of every 2 hours for Resident #8. It was acknowledge and confirmed that there was not a plan of interventions, evaluations, update assessments, and prevention programs for this resident.

Class II

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

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Based on observation and interview the facility failed to; ensure that the Residents are served food in a sanitary environment, preventing cross contamination from occurring for one of four Staff serving in the Dining , (Staff B).

The findings included:

On at 12:18 PM, a dining observation was conducted in the main dining the Lunch meal. Staff B was observed passing meals to several residents. She was observed moving the walker to another location away from the table. She was observed returning serving the food without sanitizing her hands after moving the Resident's walker.

On at 12:30 PM, an interview was later conducted with Food Service Director, who acknowledged the findings and stated that it may be a break in control.

Class III

**0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC**

Based on observation, interview and record review the facility failed to coordinate services with a third party provider for one of 10 sampled residents, (Resident # 5).

The findings included:

A review of Resident # 5 record revealed his admission date of at 02:45 PM. In a review of the Resident log entry, dated documented a left ankle , left leg with redness, and with redness. There were not any additional entries in the log for Resident # 5, until , regarding neither care nor care. Review of Resident # 5's Resident Health Assessment form( for Assisted Living (form 1823) dated documented that He was admitted with a healing and in place for . Additionally, the form states that Resident # 5 suffers from Difficulty in Walking, and Generalized Muscle . The 1823 form indicated that the Resident has mild cognition (process of knowing), with history of without behaviors.

On at 3:30 PM, an interview was conducted with Resident # 5. He was observed neat, clean and well . He wore golf shorts and a polo shirt. He was alert and oriented. There were no foul smells of or Feces in the apartment. The was exposed. He stated: "I'm sorry, I'm

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exposed and not covered up for you," The was half-full, with a dark colored strapped to his left thigh. He responded to the interview questions appropriately. He stated the Home Health Nurse comes to see him approximately twice-a-week. He stated that he had a private Aide 24-hours per day. The Aide was observed sitting quietly on the Sofa. She allowed him to answer all interview questions. He indicated that he had not experienced any problems.

Upon further review of Resident # 5's AHCA form 1823 indicates that he requires the following assistance with his Activities of Daily Living (ADL's): He ambulates with a walker and requires assistance with bathing, dressing, self-care ( ) and toileting. The 1823 form does not indicate any specific instructions regarding toileting as it relates to the care. He is able to eat independently and transfer with some assistance.

The 1823 form dated indicated that the Nursing/Treatment Services requirements note: admit with healing (Cream) in place. A in place for , (lack of control due to a , spinal cord or nerve problem).

A progress was dated at 5:42 AM, by the Home Health Agency stated: post check done. No concerns were voiced... A review of the progress notes from the Home Health Agency dated at 10:33 AM, notes the Resident has 24-hour Private Aide, and an order was sent to Home Health Agency for Physical . A progress note from the Home Health Agency dated on oral by mouth (PO), noted no adverse reaction from the Resident. An additional progress note provided by the Home Health Agency dated at 8:58 AM, Resident, still taking PO, No adverse reactions noted. The final note provided by the Home Health Agency dated at 8:24 PM, stated Resident has a to left ankle, and Home Health Nurse is doing the dressing. Based on a review of the facility records and progress note; there were not any notes or entries that coordinated care for the care provided by the Third Party Provider.

A review of the Home Health Assisted Living Facility (ALF), Coordination of Service form dated stated care and care was provided. The Home Health Agency provided the same forms dated also states that care was provided by the Home Health Agency. An additional Assisted Living Visit Coordination form dated stated that the was changed and care was provided. Based on a review of the facility records and progress note;, there were not any notes or entries that coordinated care for the care and care provided by the Third Party Provider.

A review of the Physician Orders written by the facility Physician for Resident # 5 dated do not include any mention of care nor care.

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In an interview that was conducted with the home health nurse on at 12:30PM, she stated that Resident # 5 had a history of , retention, which required ongoing , use and required nursing assistance with this care. She stated that the resident had visited his urologist monthly for routine monitoring and replacement. The nurse stated that starting in , 2017 the resident began to experience an increase in , blockages due to heavy sediment buildup in his , therefore additional home health services was ordered by his physician. The nurse stated that she visited the resident twice weekly to monitor the , function. She stated that the physician issued an order that the , is to be changed; every 2 weeks, to prevent blockages and potential , complications. The nurse stated that the resident had a private aide who emptied the collection bag for the resident. She stated that she was unaware if the facility nursing staff where making observations or monitoring the , function on the days when she was not scheduled to visit the resident. She states that the , needs to be evaluated at least daily, due to the resident's , history required changes in care. Review of the Resident # 5's facility medical record indicated no documentation of observations made by the facility nursing staff regarding the , condition and function.

A review of the Home Health Certification Plan of Care provided by the Home Health Agency dated reveals a certification period from - for an Unspecified pen on left Ankle. A request Durable Medical Equipment was noted on the form for the , bag, and Insertion. The Home Health Agency also provided the Physician Orders dated for # 2, left outer, length 1 cm. width 0.3-cm. depth 0.1 cm, and the volume 0.03 cm. The facility notes make no mention of # 1 location, onset date and care coordination. The Home Health Agency Assessment form dated , shows # 1 was located on the , described as a , documented as a , subsequent and improving. The dimensions of # 1 was not documented. The facility could not provide documentation of the location, onset, nor care coordination.

A review of the Plan of Treatment submitted by the Home Health Agency noted a , of the , Unspecified, Encounter for sitting and adjustment of , device. The form specifies Skilled Nurse to perform/teach care to left Ankle of unknown origin. Cleanse with normal , apply wet to dry gauze dressing and cover with foam adhesive dressing. Use clean/ , technique.

In an interview with the Wellness Director, on at 12:35 PM, he stated that the facility nurses do not participate in any care related to Resident # 5's , . He stated that the home health nurse was solely responsible for the resident's , care. He stated that if the Home Health Nurse had

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observed any changes in the Resident's condition he would have received verbal notification from the nurse when she visited the resident twice weekly. He stated that the facility nursing staff does not monitor or make observations of the resident's function and therefore no documentation been note in the record.

On at 02:17 PM, an interview was conducted with Staff A, an unlicensed staff member who provides direct care to the Resident's. She stated the facility Staff do not provide any care for the two Resident's with 's. She says only the Home Health Agency provide care. She went on to say that the facility does not have any Resident's who have any .

A review of the facility policy last revised on indicates Third Party Healthcare Providers who wish to provide care and services to Residents, and have a Service Agreement shall sign a Third Party Access Agreement and will supply documentation of services planned and delivered to the resident's record. Based on a review of the facility records, they could not produce a sign-in-log for the Home Health Agency nor did the facility maintain a record of the services planned and delivered to residents. The policy also states that the Wellness Director is responsible for coordinating care that is ordered by the physician/healthcare provider and documenting this in the resident's service plan.

During an interview on at 05:00 PM, a side- by-side interview with the Wellness Coordinator, in the presence of the Administrator and another Surveyor. During the interview on , the Wellness Director acknowledged the findings. Additionally the Wellness Coordinator stated that a Home Health Agency was providing services.

Class II

**0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)**

Based on observation, interview and record review, the facility failed to follow the proper protocol for assistance with self- administration of medication, for 2 of 2 opportunities observed, ( Staff A).

The findings included:

1) On at 11:04 AM. An observation was conducted with Staff A, an unlicensed direct care staff member, who assist residents with self- administration of medication on a daily bases. Staff A, was observed passing the medication to Resident # 10. She passed the medication from the bubble packet of pills into the cup without announcing the name of the medication to the Resident. A review of the

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Medication Observation Record (MOR), revealed the Resident was given the following medications: , 81 mg day, 25 mg daily, Hydrakiazine 25 mg daily, Nipederipine ER 30 mg daily, Polystyrene , 3350, mix with 8 oz. of water daily, , 500 mg daily, and an D-3, 5,000 units daily.

On at 3:00 PM, an interview was conducted with the Wellness Director. He acknowledged the findings.

2) The med pass observation was conducted at 10:45am on with Med Tech Staff A, unlicensed staff member who assists residents with self-administration of medication on a daily basis. Staff A was observed passing medication to Resident #13. The med tech thoroughly washed her hands with soap and water, then compared the label to MOR and popped the pill into a small cup and handed it to resident with a cup of water without announcing the name of the medication to the resident. Resident #13 took each pill out and took it successfully then asked what one of the pills are. The med tech responded but did not state the other medications.

On at 12:05pm an interview with the Wellness Director was conducted and he acknowledged the findings.

Class III

**0054 - Medication - Records - 58A-5.0185(5) FAC**

Based on observation, interview and record review, the facility failed to follow the training requirements to assist with self-administration of medication by Staff A signing the MOR and not observing the medication taken by the resident for 1 out of 3 sampled residents observed during a medication pass.

The findings included:

During a medication pass observation on at 11:30am by Staff A, med tech for Resident #9, the med tech handed an unopen 8oz. can of Ensure. Resident #9 left the nurses' station with the unopen 8oz. can of Ensure. The med tech did not observe the resident taking it. The med tech stated that she would check during lunch to see if she took it.
During an interview with Resident #9 at 12:15pm on , she stated that she did not drink it and said she put the can of Ensure in her refrigerator. During another interview later that same day with Resident #9 at 3:15pm in her , the resident opened her refrigerator and it was observed that there was an

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unopen 8oz. can of Ensure and an open 8oz. Ensure can with a straw in it that was not completely taken.
During an interview with Staff A, the med tech stated at 3:30pm on that she went to the dining observed the resident drink the 8oz can of Ensure and then signed the MOR for it. Copies of Resident #9 MOR and physician orders were provided and the MOR was signed by the med tech for Ensure for 8:00am.
On at 3:05pm an interview with the Wellness Director was conducted and he acknowledged the findings.

Class III

**0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC**

Based on record review and an interview, the facility failed to ensure medications be given at the prescribed times for the medications listed on the Medication Observation Record (MOR), for 2 out of 3 sampled residents (Residents #9 and #13). The physician orders and medication labels prescribe the morning medications to be taken at 8:00am. Observation of the morning medications, assisted by the med tech Staff A for Resident #9 and #13 were passed at 11:30am on and 10:30am on .

The findings included:

During a medication pass observation on at 11:30 am, Staff A assisted Resident #9 with medication that is prescribed for at 8:00am. The , 2017 MOR for Resident #9 was reviewed and the morning medications are listed for 8:00am. Observation of the pharmacy's packs, which the medications came from, had a bright red sticker on the label that stated "MORNING".

On at 10:30am, another morning medication observation of assistance with self-administration of medication for Resident #9 and #13 by med tech Staff A was conducted. It revealed that the , 2017 MOR for Resident #9 and #13 compared to the medication labels were consistent with the physician orders that was prescribed at 8:00am.

These findings were discussed with the DON on at 3:00pm and was acknowledged and confirmed.

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Class III

**0078 - Staffing Standards - Staff - 58A-5.019(2) FAC**

Based on interview and record review the facility failed to provide evidence of an annual negative ( ) test and documentation stating the Staff does not have any signs and symptoms of a communicable statement performed by the Florida Department of Health or licensed Health Care Provider for one of four employee records reviewed. Specifically, Staff A.

The findings include:

On , a review of the employee record was conducted. The employee record revealed that she was hired on as an Unlicensed Staff to assist with self-medication administration. The record revealed that the most recent test and Communicable statement was dated .

On at 04:30 PM, an interview was conducted with the Business Office Director, who handles employee training files. She stated that she was told by Health Facility Clinic, that the test and Communicable statement is required every 3 years.

On at 3:39 PM, an interview was conducted with the Administrator. She acknowledged the findings.

Class III

**0081 - Training - Staff In-Service - 58A-5.0191(2) FAC**

Based on interview and record review, the facility failed to provide or arrange the following in-service training for one of four Staff members (Staff A).

The findings included:

On , a review of the employee file for Staff A, who was hired on reveals that the following in-service training
Certificates could not be located in the employment file. The file did not contain certificates for 1 hour of elopement training, 1 hour of emergency preparedness, 1 hour of incident repotting, 1 hour of resident rights in an assisted living facility.

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On at 4:00 PM, an interview was conducted with the Business Office Manager. She stated that staff A had been there for a long time and her records for those training's may have gone with the previous owner.

Class III

**0090 - Training - - 58A-5.0191(11) FAC**

Based on interview an record review, the facility failed to arrange or provide 1 hour of ( ) training in the facility's policy for 1 of 4 direct care staff (Staff A).

The findings included:

On ./2017, a review of the employee file was conducted. It was revealed that Staff A, who was hired on ,
Did not have 1 hour training in the facility's policies and procedures on .

On , 4:05 PM an interview was conducted with the Business Office Manager, who stated that she was sure that Staff A had taken the training, but there may be another record, which may have been taken by the previous owners of the facility

Class III