Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968140	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZON HEALTHCARE INC	3114 PHILIPS HWY JACKSONVILLE, FL 32207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure complaint survey, CCR # 2012013238, was conducted on 2012. New Horizon Healthcare, Inc. had deficiencies found at the time of the visit.	A 000		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

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A 025	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on staff and family interviews, and resident record review, the facility failed to provide adequate observation of the residents whereabouts, to provide proper supervision and assessment of the resident's safety to prevent harm and injury and to contact the resident's health care provider when the resident exhibited a significant change in condition for 1 of 8 residents. (Resident #3) The findings include: Record review revealed that Resident #3 (Complainant), was admitted to the facility on . revealed the resident's diagnosis/health issue ' s included the following: affective, - essential, gait , REM sleep , and body . The Agency for Health Care Administration (AHCA) Form 1823 dated , documented the same diagnosis along with special precautions which included patient had gait with possible risk increased. A review on of the Incident/Accident report dated revealed that the Resident #3 had an incident that occurred on at 6:55 am in the day . The description of the incident was as follows: "Resident #3 got up out of her bed say she was upset and walk out and up to the gate and the staff bring her back. She was fighting the staff back , she didn ' t want to come back eventually the staff brought her back in the day . Sat her down and then got started throwing things. She stumbled with, and knocked the sign stand and to the floor. Staff	A 025		

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A 025	Continued From page 2	A 025		

got her up Staff checked patient on floor, for any injuries and got her walked her to the chair applied ice to the forehead. 7:45 are Resident ' s daughter informed of the [illegible] and incident reported completed". The note was signed by an RN. The body chart on the incident report indicated a " bump on the left side of head". Witness listed as Employees #1 and #2. Steps taken to prevent reoccurrence documented: "observe for pain and discomfort and help resident to ambulate " Form signed by Administrator on [illegible].

During an interview on [illegible] at 1:59 pm with Employee #1, she reported that when her daughter was not in the facility that the Resident 's normal behavior was screaming. She reported that she was not given medication when she screams. She reported that the day the resident [illegible] was Friday morning [illegible]. She reported the reason she [illegible] was that she was screaming and pacing up and down and acted like she wanted to throw a tantrum. She reported the staff put her in a chair in the living [illegible] then she took Resident #4 to the [illegible] that Employee #2 who was present went to the laundry [illegible] the rear of the facility. She reported that by the time she (Employee #1) got back from the [illegible] Employee #2 observed Resident #3 going for the outside gate and brought her back to living [illegible]. She reported the staff then talked to her and tried to calm her down. She reported that the resident was acting like she wanted to fight with the staff. She reported that the resident cursed by saying "leave me the F___ alone" and screaming . Employee #1 reported "Her arms were picking up things and she tried to throw them. She then reached for the metal pole and when she did she tried to throw it, she went down with it".

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A 025	Continued From page 3 Employee #1 reported that after the resident went down, " I was so scared ". She reported that the resident [illegible] on her knee and then went all the way down. She landed on her front and hit the left side of her forehead. Employee #1 reported that she checked her after she [illegible] Employee #1 reported that the resident was able to get up and walk to the nearest chair and that the staff put ice on her forehead and called the administrator. She reported that Administrator who was an RN came and checked her for pain and the Resident kept saying her forehead was hurting. Employee #1 reported at the time the bump on her head was red and [illegible], and during the course of the day it turned blue on the top and by the next morning the blue had appeared below the eye and the outer part of the eye socket was red and darker than red. During an interview with the Administrator who was an RN on [illegible] at 2:40 pm, he reported that he arrived about 7:30 am on the day of the incident and that Resident #3 was seated at the table in a chair. He reported that the staff told him that it was between shifts and that the Resident tried to leave. He reported that the night staff (Employee #2) went to the gate and could not get her to come back because she was fighting and being resistive. He reported that Employee #2 called for Employee #1 who went out to the gate and they both brought her into the facility. He reported that after they brought her in to the facility Resident #3 got up again and began to throw things. He reported that after throwing things the resident walked fast and pulled on the sign post and the sign post [illegible] with her to the floor. He reported that she [illegible] and hit her forehead on the floor. He reported that the Resident was already up and seated at the table	A 025		

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A 025	Continued From page 4	A 025		

by the time he arrived. He reported that when he arrived the staff were putting ice packs on her forehead and they told him what had happened.

He reported that he did not know much about Resident #3. He reported that she never expressed a desire to hurt herself or other residents, but would say that "she might as well be [illegible] if my daughter does not come and take me home". He reported she said things, but had never attempted to do anything to herself. he reported mentally she was not "that demented". He reported that she had lapses of memory but that was all. He reported she acted in the manner she did because she wanted to stay with her family. He reported that they did not contact anyone about her behavior because it was not constant, it came in episodes and the daughter did not want her to have too many medications so he did not contact anyone about changing medications. He reported he could not remember what medications she was taking. He reported that he could not remember if she was on any anti- [illegible] or [illegible] medications. He reported that his assessment was done for the pain and for the [illegible] and the [illegible] on her head. He stated : " At the time I did not think anything else needed to be done ". He reported he departed that afternoon [illegible] for New York as his grandson was celebrating a birthday. He reported he had a nurse that was on call, but that she was not contacted and notified of the situation. He reported that he assumed that Employee #1 would let him know by phone if there were any problems and there was no need to contact the on-call nurse to provide additional assessments. He reported that he was called by Employee #1 when the resident needed to go to the hospital the next day [illegible] He reported that he did not think that Resident #3 required

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A 025	Continued From page 5 more care than what the facility could offer. He reported that the resident did not wander. He reported that the gate was open during the day and closed at night. He reported Resident #1 had never previously attempted to go out the gate. She reported that she would mostly stay in the house but needed a wheel chair to go outside or to the dining area. He reported that on the day she tried to leave, she actually ran. He reported that when she first came she had Parkinson type ambulation so she had made good progress in ambulation to be able to run to the gate so quickly. During an interview with the other facility RN on at 3:21 pm she reported she had completed the admission assessment for Resident #3. She reported Resident #3 had in the early stages, and maybe Parkinson's. She reported she knew the Resident was under the care neurologist for her gait and ambulation. She thought that she was taking and for behavior issues. She reported that according to the resident's daughter the resident would get restless. She reported that the daughter described her behavior as threatening and verbally aggressive. She reported the resident was stubborn and that she would pack up her stuff and want to leave. She reported that the daughter did not inform her about any wandering behaviors. She reported she had no other reports at the the time of admission. She reported that the resident could not be interviewed and was not able to give a history. She reported that the resident was oriented to being in a facility but she was disoriented to time other than it was daytime. She reported that she had no reservations about the Resident's appropriateness for an assisted living facility (ALF). She reported that the	A 025		

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A 025	Continued From page 6	A 025		

resident was "formerly aggressive' and the planned interventions were to redirect her.

During an interview with the Resident's Power of Attorney (POA), at 4:43 pm on _____ she reported that she had received a phone call on Friday morning about 7:48 am from the Administrator who was RN. She reported that the administrator made it sound on the day of the call, that the accident was just a bump on the head. She stated: " I felt that he being an RN that he should have referred to the hospital. She reported that he did not do what she thought he should have done. She reported that he should have told her that she was agitated and " more hurt " . She reported that the administrator never reported to her that her mother had pain in her leg. She reported that she spoke with her mom on the phone a little while later and her mom, told her, she had pain in her leg and back, and that her leg was twisted. She reported she spoke with employee #1, and that employee #1 was told about the pain and asked to give her mother some medications for the pain. She reported that Employee #1 informed her that the resident ' s leg was not twisted. The next day she reported that her sister came to the facility at 1- 2 in the afternoon. She reported that her sister immediately saw the black eye, and observed pain when the resident was moved by the staff. The POA reported that her sister told her on the telephone that employee #1 kept telling their Mom that she was fine while her mother was screaming in pain. The POA reported that her sister took a picture of the resident and texted it to her . She reported that when she saw the picture she said : " Oh my God" and told her sister to call the ambulance and had her transported to the hospital. She reported that she had called on the day of the

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A 025	Continued From page 7 incident, in the early evening, and the staff told her Resident #3 was asleep. She reported she asked them to have her mother call her when she awoke and that she never called back. She reported that she spoke with Employee #1 on the phone. She reported that employee #1 again minimized the pain. She reported that when her mother was admitted her sister was with her and had reported to her her that their mother's leg was shorter on the affected side and that one of the nurses said it was obvious that something was [redacted]. She reported that she when she arrived at the hospital she observed a knot on forehead and cheek and that the entire right side of her face was [redacted] and the left side of her back was [redacted]. She reported that Resident #3 had stayed with her on Wednesday night [redacted] and all day Thursday [redacted] for Thanksgiving, and she had changed her clothes and she had observed no [redacted] at that time. She reported she was diagnosed with a [redacted] hip at the hospital. During an interview with the sister of the POA at 4:58 pm on [redacted] she reported that her sister who was the POA had sent her a text on [redacted] that their mom had taken a [redacted] and that she was ok with a knot on her head and a [redacted] on her knee. She reported she called Employee #1, who said not to come because she said our mom had tried to leave and that it would be better if family did not come. She reported she went to the facility on [redacted]. She reported that her mother was asleep when she arrived and she had a large black and blue area around her eye. She reported that Employee #1 came in and was trying to get her mother out of bed and her mother was screaming. She reported that Employee #1 kept saying to the resident that she could get up but her mom did not want to get out	A 025		

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A 025	Continued From page 8 of bed. She reported "I touched my mom's foot and she hollered ". She reported she took a picture of her mom ' s face and called her sister and her sister said " send to her the hospital ". She reported that Employee #1 called the owner and then said they would send her. She reported that as soon as she and her mother arrived in the Emergency , a nurse took a look at her mom that she had a hip. She stated: "She could tell by looking at her without an x-ray that she had a She reported she did not know prior to arriving at the ER that her mom's leg was twisted because she had on long pants. She reported that when the ER staff removed her pants it was clear that the leg was twisted. She reported that when her Mom was lying in the bed " you could tell that one leg was longer then the other ". She reported: " The other thing was that she was not given anything for the pain " while she had been at the facility ". A record review of the Handover book dated revealed the following: " Had a hard time with Resident #3 trying to get her up to use the She say she can ' t be on her leg it hurts when she moves it ". Note unsigned. A review of the Resident #3 record revealed no pain medication orders were on the resident record. During an further interview with the Administrator on at 5:15 pm he reported that she had no pain medication ordered and was not given anything for the pain. He reported that Employee #3 elevated her leg to relieve the pain. During an interview with Employee #1 at 5:27 am, she reported that she gave the resident# 3, two	A 025		

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A 025	Continued From page 9	A 025		

tablets of . She reported gave them the day she but reported she could not remember what time she gave it to her but "maybe after 1 pm". She reported she did not document the medication assistance on the Medication Observation Record (MOR). She looked in the Handover book notes to see when she gave the medications and reported she did not document it in the book either. A record review of the Handover book revealed no evidence of when the medication was given to the Resident #3.

During a further interview with Employee #1 and the Administrator on at 5:27 pm, Employee #1 reported that the resident would say when she was angry that she was going to hurt herself, but never acted on it. The administrator reported that he did not think that when the resident said these things that she wanted to hurt herself. He reported that the resident would be asked at the time what she felt, and she would say she wanted to see her "mother". He reported that the Resident was never observed hurting herself. Administrator reported she never really wanted to hurt herself, but she wanted to throw things. She did not want to hurt others just threw things at the wall. He reported that she would take her comb and rip her clothes off herself and then strip and pee on the carpet. The administrator reported that when you spoke to Resident #3 the behavior would stop. When the tension would get to a certain point she would act up and then she would diffuse with conversation and talking, or if the staff would give her the phone and allow her to talk to her daughter who she called mother.

A review of Resident #3 ' s record and Caregiver notes revealed the following documentation:
Caregiver notes in resident #3 dated

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A 025	Continued From page 10 " Her daughter called her and staff overheard Sharon tell her daughter she felt like walking out into the street and make a car hit her. She wanted to go home " Initialed by employee #1. Caregiver notes in resident #3 dated [redacted] " Call from daughter, she told her she feels like taking a blade and slitting her throat because she wanted to go home. " Initialed by employee #1. During the exit interview with the Administrator on [redacted] at 5:45 pm, he acknowledged that he had not completed a comprehensive assessment of the resident when the [redacted] incident occurred. He stated: "If I had it to do over I would send her straight to the hospital". He acknowledged that he did not refer her to other nursing services for ongoing follow up after the incident or medical resources before leaving for the Thanksgiving weekend and that she was not properly managed by the facility. Resident #3 [redacted] and sustained injury on [redacted] as a result of inadequate observation and supervision of the resident. In addition, inadequate observation and assessment of the resident's actual condition at the time of the injury, resulted in an increase in the resident's pain and discomfort, the assistance with pain medication by an unlicensed staff member and a delay in seeking medical attention. Ongoing documentation of [redacted] tendencies and aggressive behavior were observed by the staff, but adequate supervision and interventions to ensure the resident's safety did not occur. Class I	A 025		

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A 054	Continued From page 11	A 054		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on staff interview and resident record review the facility failed to maintain an updated and accurate medication observation record (MOR for 1 of 1 resident records sampled; The finding included	A 054		

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A 054	Continued From page 12 A record review was conducted on [redacted] Resident #3's Agency For Health Care Administration form 1823 (AHCA form 1823) documented the following medication orders: [redacted] 10 mg 2 times a day, [redacted] 750 mg 3 times a day, [redacted] 20 mg 1 time a day and [redacted] 500 mg 1 time a day and [redacted] 25-100 ½ tab 2 times a day. A review of the [redacted] 2012 MOR revealed that Resident #3 received, [redacted] 250 mg tab, 1 tablet by mouth 3 times a day which did not match orders for 750 mg to be given 3 times a day. Each medication dose entry on the MOR was initialed by the Administrator who was an RN. In addition the [redacted] 20 mg that was ordered to be given 1 time a month was not documented as given for the period [redacted] and the [redacted] 500 mg which was ordered to be given 1 time a day was not documented as given for the period [redacted]. In addition, cranberry fruit tab take 1 tab by mouth (PO) 1 daily was given to resident without evidence of physician orders but was documented on the [redacted] 2012 MOR as being given by the Administrator every day from [redacted]. Class II	A 054		
A 057	58A-5.0185(8) FAC Medication - Over The Counter (OTC) Products (8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term OTC includes, but is not limited to, OTC medications, [redacted] nutritional supplements and nutraceuticals, hereafter referred to as OTC products, which can be sold without a prescription.	A 057		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968140	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZON HEALTHCARE INC	3114 PHILIPS HWY JACKSONVILLE, FL 32207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 057	Continued From page 13 (a) A stock supply of OTC products for multiple resident use is not permitted in any facility. (b) OTC products, including those prescribed by a licensed health care provider, must be labeled with the resident ' s name and the manufacturer ' s label with directions for use, or the licensed health care provider ' s directions for use. No other labeling requirements are necessary nor should be required. (c) Residents or their representatives may purchase OTC products from an establishment of their choice. (d) A facility cannot require a licensed health care provider ' s order for all OTC products when a resident self-administers his or her own medications, or when staff provides assistance with self-administration of medications pursuant to Section 429.256, F.S. A licensed health care provider ' s order is required when a licensed nurse provides assistance with self-administration or administration of medications, which includes OTC products. When such an order for an OTC product exists, only the requirements of paragraphs (b) and (c) of this subsection are required. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the facility failed to ensure Over the Counter medications were ordered and given appropriately for one of three residents (#3). The findings include: A review of the Resident #3 record revealed no medication was ordered for pain. During further interview with the Administrator on at 5:15 pm he reported that Resident #3 had no pain medication ordered and was not given anything for the pain. He reported that Employee #3	A 057		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968140	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZON HEALTHCARE INC	3114 PHILIPS HWY JACKSONVILLE, FL 32207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 057	Continued From page 14 elevated her leg to relieve the pain. During an interview with Employee #1 at 5:27 pm, she reported that she gave the resident# 3, two tablets of . She reported she gave them the day she but reported she could not remember what time she gave them to her but stated "maybe after 1 pm". She reported she did not document the medication assistance on the Medication Observation Record (MOR). She looked in the Handover book of notes to see when she gave it and there was no evidence of medication assistance documented. A review of the Handover book and the MOR revealed no documentation of when the medication had been given to Resident #3 and no physician orders for for Resident #3. Class II	A 057		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
New Horizon Healthcare Inc.
3114 Philips Hwy.
Jacksonville, FL 32207

Re: CCR #2012013238

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2012 by a representative of this office.

Attached is the provider's copy of the State (3020) 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 **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey. **A recommendation for sanction has been forwarded to the Central Office in Tallahassee for the Class I and II deficiencies. This action, if taken, will be a matter of separate correspondence from the Central Office in Tallahassee.**

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. Should you have any questions please call this office at

Sincerely,

Keisha Woods

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

W/sm
Enclosure\

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