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 |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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<br><br>These are the results of a Biennial survey conducted on through , at Horizon Bay Vibrant Retirement Living, an Assisted Living Facility, in Sarasota, Florida.<br><br>The following deficiencies were cited: | A 000 | | |
| A 025 | 58A-5.0182(1) FAC Resident Care - Supervision<br><br>An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following:<br>(a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C.<br>(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.<br>(c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community.<br>(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.<br>(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 | A 025 | | |

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 |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 025 | Continued From page 1<br>the provision of additional services.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to provide a written record of the care and services for 2 (Residents #4 and #11) of 2 residents; Resident #11, who was admitted to Hospice services and for notifying Resident #4's health care provider for a weight loss, had no nutritional and ...l risk assessments.<br><br>The findings include:<br><br>1. Resident #11 was observed on at 11:00 a.m. on the second floor of the Atrium with Resident Care B at a table in the hallway drinking her Boost supplement. Resident #11 was observed to be very thin.<br><br>An interview with the Resident #11 revealed she did not want to finish the drink after encouragement. Staff responded that the resident had "lost a lot of weight" and was now on Hospice.<br><br>Record review revealed Resident #11 was admitted to the facility on ... with diagnosis including ... and acute ... Record review revealed the resident was admitted with a weight of 106 pounds. The only health assessment in the record was dated ... Other weights documented in the record revealed Resident #11 weight was 78 pounds on .<br><br>The facility has an electronic system of documentation for nursing notes. Interview with two nursing staff on ... at 3:00 p.m. | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 025 | Continued From page 2 | A 025 | | |

revealed nursing only documents by exception. The staff were unable to provide any significant changes in the resident Activities of Daily Living or increased pain.

Further record review revealed Resident #11 was referred to a Hospice facility and accepted for services. The facility record lacked a new health assessment for change in condition that indicated the need for Hospice services on .

Interview with the Director of Nursing on at 4:00 p.m. confirmed there was no other health assessment for Resident #11. She could not provide nurse's notes that lead to the referral to Hospice or the need for additional services.

2. Staff C produced a copy of the electronic MOR for the months of to . The first documented weight is 128 on . Resident #4's weight record documentation on was 120 . This is a weight loss of 8 in 8 days. Her weight continued to drop to 114 documented on , which is an additional 6 for a total weight loss of 14 over 20 days. No documentation of MD notification of this weight loss was found in the residents record. No nutritional assessment documentation found in residents record related to weight loss. Documentation was found in the residents record of history of chewing and swallowing problems leading to choking. The resident was on a regular, no added salt diet.

An interview was held with the Wellness Director on at 10:04 a.m. She verified the facility was not able to find documentation of a phone call to the MD to notify of weight loss or nutritional assessment related to significant weight loss.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 025 | Continued From page 3<br><br>In an interview with Staff C on at 5:00 p.m. she stated "The Home Health Nurse should have called the doctor about the weight loss for Resident #4."<br><br>3. AHCA form 1823 dated states Resident #4 needs Physical and Occupational No documentation found in resident's record of risk precautions being put in place. Assessment and care plan dated beginning on does not assess the resident as a risk. No documentation of precautions being put in place for Resident #4. Documentation of Management Investigation of on for Resident #4. Document also states the resident has in the last 3 months prior to this on<br><br>An interview was held with Staff C on at 9:40 a.m. She verified that she could find no documentation of risk interventions for this resident with a history of<br><br>Class III | A 025 | | |
| A 030 | 58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures<br><br>(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.<br>(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure | A 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 030 | Continued From page 4 | A 030 | | |

for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida _ _ _ _ Hotline " 1(800)9€ or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 030 | Continued From page 5 | A 030 | | |

federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical ..... shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from ... and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of

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 |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 030 | Continued From page 6 | A 030 | | |

other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is

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 |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 030 | Continued From page 7 | A 030 | | |

harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on observation and interview with facility staff, the facility failed provide a clean and safe living environment for 2 (Residents #6 and #18) residents and treat 2 (Residents #23 and #8) residents with personal dignity in dining. Additionally, Resident #4 had without an assessment to keep her safe.

The findings include:

1. During the initial tour of the second floor of the Atrium on at approximately 10:45 a.m. after interviewing Resident #6 and getting consent from the resident to enter her the

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 |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 030 | Continued From page 8 | A 030 | | |

surveyor and the Administrator entered [redacted] 203. Observation revealed the bed was not made with one small sheet covering the mattress. The [redacted] a stale musty odor. The [redacted] the residents washed underwear hanging on knobs. There were 2 laundry baskets that had clothes and magazines in them. The carpet had stains.

An interview was held with the resident on [redacted] at 10:45 a.m., The resident stated, "Housekeeping do well to keep things clean. I have a lot of things laying around."

Interview with the Resident Care Aid on [redacted] at 11:00 a.m. revealed this [redacted] resident often feels staff are taking her personal possessions.

2. Observation on [redacted] at 5:00 p.m. revealed Resident #18 lying on his bed in his [redacted]. The nightstand had a lamp that had no light bulb in it and no shade. Staff reported Resident #18 is very [redacted] and spends the entire day in his [redacted].

3. On [redacted] between 5:20 p.m. and 5:50 p.m. in the first floor Atrium dining [redacted], Resident #23 sat with a private aid waiting for her dinner. The resident received a puree diet. She stated she did not like this food. Staff reported that she was recently changed to puree.

Interview with the Director of Nursing on [redacted] at 11:00 a.m. revealed there was no physician order for Resident #23's diet order to change. She could not explain the [redacted] of why the resident waited so long for her dinner and was served a puree diet.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 030 | Continued From page 9 | A 030 | | |

4. Interview with Resident #8 on at 11:05 a.m. revealed she and her husband have meals in the first floor Atrium dining . . . . . She stated the food is not always good. She stated the 4 residents at the table are not always served at the same time. She further stated you have to wait up to 45 minutes for your meal.

Observation on at 5:30 p.m. during the supper meal confirmed Resident #19 waited 50 minutes to receive her meal. Residents who were served at 5:15 p.m. waited a 45 minutes for dessert to be served.

5. AHCA form 1823 dated states Resident #4 needs Physical and Occupational No documentation found in resident's record of risk precautions being put in place. Assessment and care plan dated beginning on does not assess the resident as a risk. There was no documentation of precautions being put in place for Resident #4.

There was documentation of Management Investigation of on for Resident #4. Document also states the resident has in the last 3 months prior to this on

In an interview with Staff C on at 9:40 a.m. she verified she could find no documentation of risk interventions for this resident with a history of

Class III

| | | | |
|---|---|---|---|
| A 051 | 58A-5.0185(2) FAC Medication - Pill Organizers | A 051 | |

(2) PILL ORGANIZERS.
(a) A " pill organizer " means a container which

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 051 | Continued From page 10 | A 051 | | |

is designed to hold solid doses of medication and is divided according to day and time increments.
(b) A resident who self-administers medications may use a pill organizer.
(c) A nurse may manage a pill organizer to be used only by residents who self-administer medications. The nurse is responsible for instructing the resident in the proper use of the pill organizer. The nurse shall manage the pill organizer in the following manner:
1. Obtain the labeled medication container from the storage area or the resident;
2. Transfer the medication from the original container into a pill organizer, labeled with the resident ' s name, according to the day and time increments as prescribed;
3. Return the medication container to the storage area or resident; and
4. Document the date and time the pill organizer was filled in the resident ' s record.
(d) If there is a determination that the resident is not taking medications as prescribed after the medicinal benefits are explained, it shall be noted in the resident ' s record and the facility shall consult with the resident concerning providing assistance with self-administration or the administration of medications if such services are offered by the facility. The facility shall contact the resident ' s health care provider regarding questions, concerns, or observations relating to the resident ' s medications. Such communication shall be documented in the resident ' s record.

This Statute or Rule is not met as evidenced by:
Based on record review and interview the facility failed to maintain a list of current medications for 1 (Resident #1) of 2 residents reviewed when Resident #1 was utilizing a pill organizer.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 051 | Continued From page 11<br>The findings include:<br><br>Resident #1 utlizes a pill organizer set up by staff from a nurse registry per his request. Review of the Assisted Living Facility (ALF) records revealed that the ALF did not have a current list of the medications Resident #1 was taking.<br><br>During an interview on ..... at 3:45 p.m. Staff C stated that they did not know what medications and or doses Resident #1 was currently taking.<br><br>Class III | A 051 | | |
| A 082 | 58A-5.0191(3) FAC Training - .....<br><br>(3) .....<br>.....<br>Pursuant to Section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of Section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the Section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12) of this rule.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review and staff interview the facility failed to insure that 1 (Staff A) of 4 employees received the training for .....<br><br>The findings include:<br><br>Staff A did not have documentation of ... training | A 082 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 082 | Continued From page 12<br>in her employee record.<br><br>During an interview on at 5:15 p.m. Staff E confirmed that Staff A did not have documentation training in her employee record.<br><br>Class III | A 082 | | |
| A 088 | 429.177 FS<br>Disclosures<br><br>Patients with 's or other related ; certain disclosures.-A facility licensed under this part which claims that it provides special care for persons who have 's or other related must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The facility must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with 's or other related offered by the facility and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the facility 's records as part of the license renewal procedure.<br><br>This Statute or Rule is not met as evidenced by: Based on employee record review and interview the facility failed to insure 2 (Staff A and Staff B) of 4 employees received 1 and 2 training.<br><br>The findings include: | A 088 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 088 | Continued From page 13 | A 088 | | |

Review of employee record for Staff A and B revealed they did not have documentation of [illegible] 1 and 2 training.

During an interview on [illegible] at 5:15 p.m. Staff E verified that these employees did not have documentation of [illegible] training in their employee record.

Class III

| | | | |
|---|---|---|---|
| A 090 | 58A-5.0191(11) FAC Training - Do Not [illegible] Orders | A 090 | |

(11) [illegible] TRAINING.
(a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policies and procedures regarding [illegible] within 60 days after the effective date of this rule.
(b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policy and procedures regarding [illegible] within 30 days after employment.
(c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on record review and staff interview 2 (Staff A and Staff B) of 4 employee records reviewed did not have documentation of required [illegible] training.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 090 | Continued From page 14<br><br>The findings include:<br><br>Review of employee records revealed Staff A and Staff B did not have documentation of training.<br><br>During an interview on at 5:15 p.m. Staff E verified that Staff A and Staff B did not have documentation of training.<br><br>Class III | A 090 | | |
| A 093 | 58A-5.020(2) FAC Food Service - Dietary Standards<br><br>(2) DIETARY STANDARDS.<br>(a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program.<br>(b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows:<br>1. Protein: 6 ounces or 2 or more servings;<br>2. Vegetables: 3 5 servings;<br>3. Fruit: 2 4 or more servings; | A 093 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 093 | Continued From page 15 | A 093 | | |

4. Bread and starches: 6 11 or more servings;
5. Milk or milk equivalent: 2 servings;
6. Fats, oils, and sweets: use sparingly; and
7. Water.

(c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.

(d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months.

(e) Therapeutic diets shall be prepared and served as ordered by the health care provider.

1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care provider ' s order indicates that such monitoring is necessary. However, the food items which enable

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 093 | Continued From page 16 | A 093 | | |

residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility.
2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary.
(f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand.
(h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 093 | Continued From page 17<br>accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, review of the menu, and interview with facility staff, the facility failed to post the current planned menu, supply adaptive equipment for Resident #19, and use appropriate size utensils to serve residents dinner in the Atrium first floor dining .<br><br>The findings include:<br><br>1. Observation of the posted menus outside the dining , in the Atrium on revealed the current weeks were not posted.<br><br>Interview with the Food Service Director on at 5:00 p.m. verified the posted menu was from 2 weeks ago.<br><br>2. Observation on in the first floor Atrium dining 5 and 6 p.m. revealed no residents had adaptive equipment. Observation on at 12:30 p.m. revealed Resident #19 was served her plate with a plate guard. Staff revealed the resident has been using a plate guard for several weeks and the resident aid put it on the plate.<br><br>Interview with the Director of Nursing on at 3:00 p.m. confirmed Resident #19 should have | A 093 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 093 | Continued From page 18<br>consistently been offered the plate guard.<br><br>3. Observation of the tray line on the [redacted] with the Food Service Director ( FSD) revealed the dietary staff cut slices from the meat loaf touching the meat loaf with gloved hands. The staff did not change gloves after touching the meat. When the surveyor asked the staff what the portion size was, she stated she just cut the slices. The FSD stated he was unaware of the portion size for the entrees. He proceeded to call the kitchen to find out how many ounces should be served. The second entree was seafood casserole and bow tie pasta. Again, the staff used a slotted spoon to serve the entree. There was no awareness of how much should be served. The staff served the pasta entree and also put rosemary potatoes in a small plate. The FSD confirmed the potatoes should have been served with the meatloaf. There was no need for double starch to be served to the residents who received the seafood entree.<br><br>Class III | A 093 | | |
| A 162 | 58A-5.024(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name;<br>2. [redacted]<br>3. Race;<br>4. Date of birth;<br>5. Place of birth, if known;<br>6. Social security number;<br>7. Medicaid and/or Medicare number, or name of other health insurance<br>8. Name, address, and telephone number of next of kin, responsible party, or other person the | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 162 | Continued From page 19 | A 162 | | |

resident would like to have notified in case of an emergency, and relationship to resident; and
9. Name, address, and phone number of health care provider, and case manager if applicable.
(b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C.
(c) Any health care provider ' s orders for medications, nursing services, therapeutic diets, , or other services to be provided. supervised, or implemented by the facility that require a health care provider ' s order.
(d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C.
(e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C.
(f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually.
(g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident ' s contract.
(h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C.
(i) A copy of the resident ' s contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C.
(j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 162 | Continued From page 20 | A 162 | | |

monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S.
(k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S.
(l) A copy of Alternate Care Certification for Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services.
(m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable.
(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C.
(o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following:
1. A log listing the names of residents participating in this arrangement;
2. The resident demographic data required under this subsection;
3. The medical examination described in Rule 58A-5.0181, F.A.C.;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 162 | Continued From page 21<br>4. The resident ' s contract described in Rule 58A-5.025, F.A.C.; and<br>5. A health care provider ' s order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.<br>(p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility.<br>(q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to maintain an updated copy of a medical examination for 1 (Resident #11) of 1 hospice resident.<br><br>The findings include:<br><br>Record review revealed Resident #11 was admitted to the facility on ... with diagnosis including ... and acute ... The only health assessment in the record was dated ...<br><br>Record review revealed Resident #11 was referred to Tidewell hospice and accepted for services. The facility record lacked a new health assessment for change in condition that indicated | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11942812 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HORIZON BAY VIBRANT RET LIVING 449 | 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236 |

| (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 162 | Continued From page 22<br><br>the need for hospice services on [redacted]. Interview with the Director of Nursing on [redacted] at 4:00 p.m. confirmed there was no other health assessment for Resident #11. She stated she would contact hospice immediately to have the required health assessment completed.<br><br>Class III | A 162 | | |

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Horizon Bay Vibrant Retirement Living 449
730 South Osprey Avenue
Sarasota, Florida 34236

Dear Administrator:

Re: Biennial survey

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representatives 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 22013 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 surveyors. Should you have any questions please call this office at 239-335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

HW:ss
Enclosure: State Form

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372