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
	AL11965424	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON BAY VIBRANT RET LIVING 445	217 BOSTON AVENUE ALTAMONTE SPRINGS, FL 32701

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A 000	Initial Comments [redacted] complaint inspection CCR#2012010774 was conducted. The facility had a deficiency found during 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 resident record review and interviews the facility failed to ensure it provided care and services appropriate to the needs of residents admitted to the facility for 2 of 3 sampled residents: failed to ensure medications were readily available; not shared by residents (#2) and failed to ensure safe handling of medication when a resident went out (#3). Findings: Resident #2 had an incident dated ... that indicated resident complained of ..., sent to ER for evaluation and treatment. Review of the MAR indicated missed doses of ... 9/1 and 9/2, Toresemide on 9/1, 9/2 and 9/4. On 9/5 the community was notified she was admitted to hospital. The severity code was indicated as harm/injury with admission to hospital". Health assessment report (1823) dated ... listed diagnoses of A-fib, ..., elevated ... and .... The assessment did not address the type of assistance that was needed for the supervision with self-administration of medications. Facility note dated ... indicated the resident sent to the Emergency ... (ER) via ambulance for complaints of breathing difficulty VS (vital signs) ..., P 95 02 SAT 86%. Late entry dated ... indicated at approximately at 9 AM resident complained of not feeling well, ... was .... The resident went and lay down, doctor was called. Before lunch ... was taken and was .... The doctor's office opened after lunch, triage nurse was made aware of the ... reading, with the last one at lunch .... Shortly after the triage nurse called and said to continue meds as scheduled in AM, will continue to monitor. Note	A 025		

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A 025	Continued From page 2 dated 9/7 indicated executive director spoke with daughter and told her she was doing much better. On ... she returned to the facility from rehab. The 2012 MOR listed ... 160 mg tablet Valsatran give 2 tablets daily for ... at 5 AM .On 9/1 and 9/2 the MOR indicated "waiting for delivery, dng", 9/3 and 9/4 were blank. The 2012 MOR listed Torsemide 20 mg take 2 tablets= 40 mg at 5 AM every morning for ... On 9/1, 9/2, 9/3 and 9/4 the MOR indicated "dng" medication was not given awaiting delivery. The legend on the MOR indicated "dng" meant drug not given. The 2012 MOR listed ... inhalation solution 0.083% one twice daily and was blank on ... and ... AM & PM. 0.02% one twice daily was blank from ... to ... AM &PM, Carvidol 6.25 mg one twice daily was blank from ... to ... in the AM; 25 mg daily was blank on ... to ... The physician order dated ... and attached to the health assessment dated indicated diagnoses of A- fib, acute , chronic anticoagulation, , and seasonal The assessment did not indicate the type of assistance if any that was needed with self-administration of medications. The addendum to ACHA form 1823 dated and signed by the healthcare provider sheet listed ... inhalation solution 0.083% one twice daily via 0.02% inhalation solution one twice daily via , Carvidol 6.25 mg one twice daily, hold if SBP less than 110 or DBP less than 60 and 25 mg daily among some of the resident's many mediations. The facility's medications & treatment -availability effective ... and last revised indicated:	A 025		

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A 025	Continued From page 3 Overview-it is the policy that all currently ordered medications will be available to the resident. Policy in detail indicated the facility was responsible obtaining newly or refill medications and treatments, unless otherwise agreed by the resident/family or representative. If the family assumes the responsibility of obtaining the medications, but the medications are not delivered within 2 days prior to depletion, the facility would order the medication from the preferred provider and the family would be responsible for the charges. The medication & treatment- medication error policy effective [redacted] and last revised on [redacted] indicated incorrect time (failure to administer a medication at a prescribed time) and a missed dose (failure to administer a medication) constitute a medication error. Review of the investigation conducted by the facility's executive director revealed a memo from Vanguard Advanced Pharmacy Systems dated [redacted] that indicated to please post. The memo served as a reminder the pharmacy would be closed Monday 3 (bold letters) for Labor Day. They would reopen on Tuesday 4 (bold letters). Their on call pharmacist would be available for emergencies, listed the phone number and indicated option #2, then #5 in bold letters. The investigation continued. A Licensed Practical Nurse (LPN) (nurse A) was told by a caregiver on [redacted] that resident #2 was out of [redacted] and Torsemide. The LNP ordered the medication by fax and marked urgent. She spoke with resident #2 and gave her a [redacted] that belonged to another resident. On 9/4 at approximately 8:30 -9 AM resident told the same nurse that she still did not have her medication. The LPN checked her [redacted] and gave her half the pill that belonged to another resident. The LPN approached the	A 025		

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A 025	Continued From page 4	A 025		

director of wellness and explained about the medication not being in yet. The LPN called the doctor's office and at 2:15 PM his nurse stated that she could resume on [redacted]. The resident was then complaining of difficulty breathing, unsteadiness and was diaphoretic, was send to ER for evaluation. "During the interview the nurse told the writer that she thought about bringing one of her husband's water pills to give to the resident".

Another LPN (nurse B) stated she became aware the resident was out of [redacted] and Torsemide on 9/2, she faxed a request on 9/2 and 9/3. When she came in on 9/4 at 2:30, the medication had not arrived; she contacted the pharmacy again and faxed a prescription.

The Health and Wellness Director became aware of the situation on [redacted] when nurse A told her about it. She asked why had nothing been done about it. Nurse A said she was off 9/2 and 9/3.

The director called the pharmacy and spoke with the liaison who informed her that the medication was scheduled for delivery on 9/5. She told the pharmacy it needed to be delivered as an emergency from Walgreen's, the medication arrived that day after the resident went to the hospital.

The Regional Director of Health spoke with the pharmacy. They informed her that the pharmacy was closed for Labor Day weekend. He confirmed a fax was received on [redacted] regarding [redacted] and Torsemide. He added there was an emergency number that the nurses could have called.

Interview with resident and daughter at approximately 1:30 PM stated it was an unfortunate, terrible, terrible, mistake. They both indicated "We love it here, won't move. We were asked if we wanted the staff fired, we said no". The resident stated she suffered a mild [redacted]

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A 025	Continued From page 5 as result. The executive director stated at approximately 2 PM that if the resident used Vanguard there was not an increase in the charge. If there was an outside pharmacy there is no charge for this. The emergency number, to contact the pharmacy and speak with a person was posted on the wall in medication by the fax. From this point on if Vanguard does not respond, Walgreen's (local pharmacy) will be used 2. Review of the facility's incident log at approximately 10 AM revealed that on at 6 PM resident #3 asked for 5 PM & 9 PM medications as he was going out to dinner with his family. He drank all the medications together. No adverse reaction noted. The severity code was indicated as no apparent harm/injury. Resident record review on said date at approximately 11 AM for resident #3 revealed a health assessment report dated that listed diagnoses of , Parkinson's, history of , chronic insufficiency. He needed assistance with self-administration of medications. According to the assessment he was mostly alert. He also was under the care of hospice. Late entry facility note dated indicated that on the resident was going out with family and took both 5 PM and 8 PM medications at the same time. No adverse effects MD aware. Facility note dated indicated the resident was out with family, passed out was taken to ER, where he stayed with and other problems". Facility note dated indicated he returned on and on 11/9 family signed the resident up with hospice. Continued review revealed the 2012 Medication Observation Record (MOR) listed the following medications due at 5 PM and 9 PM ":	A 025		

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A 025	Continued From page 6 /Levidopa mg four times a day 9 AM , 1 PM, 5 PM and 9 PM ; 12.5 mg one with breakfast, supper with or after meals 9 AM &5 PM; Comtam 200 mg one at 9 AM, 1 PM, 5 PM and 9 PM given with take one at 9 PM; Methrocaban 500 mg take 2 tables at bedtime- 9 PM; 20 mg one every evening 6 PM; EX 100 mg 2 tablets twice daily 9 am & 5 PM; Plus 8/6 -50 mg one at bedtime 9 PM; 0.25 mg one twice daily 9 AM &8 PM. The hospital discharge summary dated listed the medications but did not list admitting diagnosis. The executive director stated at approximately 3 PM the medicine was given to resident to go out with family; he took them all together, the 5 PM and 9 PM at once. Class II	A 025		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Horizon Bay Vibrant Ret Living 445
217 Boston Avenue
Altamonte Springs, FL 32701

Dear Administrator:

Re: CCR #2012010774

This letter reports the findings of a state licensure survey that was conducted on . 2012 by representative(s) 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.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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