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
	AL11965994	A. BUILDING: _____ B. WING _____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZON NORTH	8112 NW 74TH TERRACE TAMARAC, FL 33321

(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 Assisted Living Facility standard biennial licensure survey with Limited Nursing Services (LNS) was conducted on ... New Horizon North, had licensure deficiencies found at the time of the visit.	A 000		
A 025 SS=D	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 interview and record review, the facility failed to provide care and services for the assessment and monitoring of a for Residents #2 and #6; failed to assess and monitor the status of an tube for Resident #4 and failed to document a significant change in the status requiring the use of for Resident #4. The findings include: 1) Resident #2 was admitted to the facility on with a documented diagnosis of and Review of the Resident Observation Log dated documents "Family states that she was admitted in the rehab due to a in her apartment. She stayed there for approximately two and a half weeks". There is no evidence of documentation on admission the resident was admitted with a Review of a Progress Note dated , the day after admission, documents "RN (Registered Nurse) evaluation done and assessment completed for (unclear if is physical or patient) evaluation and treatment. AAO (awake, alert, oriented) x 3. noted to RUE (right upper extremity), to hand and fingers. C/O (complains of) pain 8-9, got medicated. to f/u (follow up)". Review of Resident #2's record revealed no evidence of documentation of the assessment or monitoring of the resident's right arm . There is no further evidence of documentation regarding the of the resident's hand and fingers as	A 025		

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A 025	Continued From page 2	A 025		

documented by the RN on [redacted] nor are there any further pain assessments.

Review of the Resident Observation Log dated [redacted] documents "saw orthopedic".

Review of a Service Plan dated [redacted] documents a RN evaluation was done for Physical [redacted] services. However, there is no evidence of documentation of what body part the [redacted] was to treat.

Review of the resident's record revealed a notation in the physician orders section dated [redacted] for an [redacted] Procedures scheduling request for an open reduction internal fixation (ORIF) for the right [redacted]

Review of the Resident Observation Log dated [redacted] documents "taken by family to see orthopedic doctor for follow up visit".

Review of the Resident Observation Log dated [redacted], documents "patient given the all clear to do corrective orthopedic surgery".

Review of a physician progress note dated [redacted], documents "patient is cleared for orthopedic surgery by [redacted] and primary care physician".

Review of the resident's record and the Limited Nursing Services (LNS) log revealed no monitoring or assessment of the resident's right arm [redacted] from [redacted] through [redacted] until when the physician documented on a progress note the "resident is status post [redacted] of the [redacted]

Review of the Resident Observation Log dated

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A 025	Continued From page 3 documents, "resident was taken by family to do corrective surgery to right hand". There is no evidence of documentation in the resident's record when the resident returned to the facility, what surgical procedure was done or any assessment or monitoring of the resident status post-surgery with a right arm ..... Review of the Resident Observation Log dated ..... documents, "resident was taken by family for follow up visit to orthopedic doctor". Review of the resident's record and LNS log revealed no evidence of documentation of the monitoring or assessment of the resident's right arm ..... from ..... to ..... until a physician progress note dated ..... documents 'resident wearing fiberglass short arm .....' Review of a Progress Note by a RN dated ..... documents, ... removed client doing well with ..... No follow up required". Review of the resident ' s record and LNS log revealed from ..... through ....., no evidence of documentation of an assessment or monitoring of the resident's right arm ..... or on what specific date the ..... was removed. On ..... at approximately 2:00 PM, an interview was conducted with the Administrator who confirmed resident #2 was admitted to the facility with a right arm ..... Additionally, she confirmed there were no assessments or monitoring of the resident's right arm ..... since the RN documented on a progress note dated ..... the resident had a ..... and pain to the right hand. The Administrator was	A 025		

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A 025	Continued From page 4 unable to provide an accurate date when the right .... was removed. An inquiry was made to the Administrator why Resident #2 was not initiated under LNS and the Administrator replied by stating "the LNS regulations are not clear and she did not think to put the resident under LNS". Additionally, the Administrator, a Certified Nursing Assistant, stated she was monitoring the resident's .... However she did not document that anywhere. Monitoring and assessment of a .... is beyond the scope of practice for a Certified Nursing Assistant. 2) Resident #4 was admitted to the facility on ..... with a diagnosis of ..... and ..... aneurysm. Review of the physician assessment 1823 dated ..... documents the resident has a ..... tube (tube inserted into the abdomen to administer liquid food into the stomach), is no longer on ..... tube feedings and needs to follow up with his ..... physician and primary care physician (PCP). Review of the Resident Observation Log dated ..... documents the resident was admitted from a rehabilitation center and the resident "resident has a G-tube intact. However, the resident eats solid food. Resident scheduled to follow up with PCP on ..... Review of the Resident Observation Log dated ..... documents the "resident saw his PCP on this date. Meds reviewed. Script written for meds. Referral scheduled to remove G-tube on ..... at 'name' of hospital". Review of the Resident Observation Log dated ..... documents the "resident taken to hospital to remove ..... tube. Procedure went well. Follow up appointment to be made to see attending doctor".	A 025		

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A 025	Continued From page 5	A 025		

Further review of the resident's record revealed no evidence of documentation of the assessment or monitoring of the tube from the date of admission on through when the tube was removed at the hospital and no evidence of documentation the resident was capable of independently monitoring the tube.

On at 2:00PM, an interview was conducted with the Administrator who stated she thought it was alright to admit a resident with a tube if it was not being used. An inquiry was made to the Administrator who was monitoring the status of the tube and she stated the resident was doing his own thing and as far as she knew it was just taped to his stomach and she did not realize the status of the tube should have been monitored or assessed.

On at 12:00PM, a medication pass was observed with the Medication Technician. Resident #4 was given 150 mg tab with his lunch. An interview was conducted with the Medication Technician inquiring why the resident was on an she stated she thought it was for his . On at 12:05PM, an interview was conducted with Resident #6 who stated he had a abscess and his dentist called in a prescription for the and he has been on them for a few days and he is noticing a difference with the pain and discomfort of his . Review of the Resident Observation Log revealed no evidence of documentation for the assessment or indication why the resident was started on . Review of the physician orders, revealed no evidence of a physician order for the . On at 1:45PM, an interview was conducted with the Administrator who stated the doctor called the order into the pharmacy and the pharmacy delivered the medication. However

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A 025	Continued From page 6	A 025		

she does not have a copy of the order. She stated she will contact the pharmacist and have the order faxed to the facility, so there will be a copy in the record.
3) Resident #6 was admitted to the facility on [redacted] with a diagnosis of [redacted]. Review of the Resident Observation Log revealed documentation dated [redacted] at 4:30PM; the resident had a witnessed [redacted] and was sent to the hospital for an evaluation and x-rays of her left leg. Documentation on [redacted] at 11:45PM, states the resident "returned from hospital with family who reports that resident left ankle was broken". There was no evidence of documentation of the status of the resident or any limitations the resident might have.
The next entry in the Resident Observation Log dated [redacted] states, "patient was taken to orthopedic doctor for the first time".
Review of the Resident Observation Log dated [redacted] documents, "client had [redacted] put on by orthopedic doctor on this date".
Review of the Resident Observation Log dated [redacted] documents, "client went to do x-ray on ankle at orthopedic office".
Review of a Health Care Communication Form not dated and signed by the physician documents, the resident to be "NWB (non weight bearing) on left and return in 3 weeks for [redacted] removal".
Review of the Resident Observation Log dated [redacted] documents, "Client had [redacted] removed by orthopedic doctor on this date".
On [redacted] at 1:50 p.m. an interview was conducted with the Administrator who stated the resident had a hard [redacted] to the left ankle. She stated the resident was being monitored by the LNS nurse once a week. However, she could not produce any evidence of documentation of any assessments, monitoring or progress notes

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A 025	Continued From page 7 related to the resident's left ankle [redacted]. The Administrator stated, "maybe the LNS Nurse took the notes with her'. However, the Administrator made no attempt to contact the LNS nurse. Review of the resident's record and LNS log revealed no evidence of documentation of an assessment or monitoring of the resident's left ankle from [redacted] when she sustained the [redacted] and [redacted] her left ankle up to and including the date the [redacted] was removed on [redacted]. Class III	A 025		
A 054 SS=D	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 [redacted] 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.	A 054		

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A 054	Continued From page 8 (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 observation, interview and record review, the facility failed to ensure the Medication Observation Records (MORs) were accurate for 3 out of 3 residents sampled for medication reconciliation, (Residents #1, #2 and #4) as evidenced by the doses not documented for Residents #1 and #2; and inaccurate route for Resident #4. The findings include: On at 1:30 p.m. medication reconciliation was done with the facility Medication Technician. 1) Review of the MORs for Resident #1 revealed an order for medication), take one tablet by mouth daily. There is no dosage documented on the MOR. Review of the pill pack documents the dose to be 25 mg. 2) Review of the MORs for Resident #2 revealed an order for pill taken for , take one tablet by mouth daily. There is no dosage documented on the MOR. Review of the pill pack documents the dose to be 25 mg. 3) Review of the MORs for Resident #4 revealed an order for Cerovite Liquid supplement), take 15 ml via daily. Review of Resident #4's record revealed the tube was removed on	A 054		

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A 054	Continued From page 9 On [illegible] at 1:50PM, an interview was conducted with the Administrator who concurred the MOR needs to have the medication dosage and correct route of administration and she will contact the pharmacy to have the corrections made. Class III	A 054		
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, [illegible] 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. (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: 1. Protein: 6 ounces or 2 or more servings; 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings;	A 093		

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A 093	Continued From page 10 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 residents to comply with the therapeutic diet shall be identified on the menus developed for use in	A 093		

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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 accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food

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A 093	Continued From page 12	A 093		

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.

This Statute or Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure that substitutions were noted before or when the meal was served and failed to maintain the substitutions for 6 months.

The findings are:

During observations of the lunch meal at approximately 12:00PM on it was noted that the posted menu was not dated for the current week. In addition, the menu listed a turkey sandwich, however, the residents were being served a chicken salad sandwich. The residents were also being served pastry instead of pudding, and no sugar added canned fruit for the

Further review of the menus revealed a 4 cycle menu, one for each week of the month. The Administrator was interviewed on at 12:25PM, she confirmed the menus were not dated to differentiate what week of the cycle they were using. She also revealed the facility did not write down the substitutions and did not maintain 6 months of substitutions, on record.

Class III

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AN278	Continued From page 13	AN278		
AN278 SS=D	58A-5.031(3) FAC LNS - Records (3) RECORDS. (a) A record of all residents receiving limited nursing services under this license and the type of service provided, shall be maintained. (b) Nursing progress notes shall be maintained for each resident who receives limited nursing services. (c) A nursing assessment conducted at least monthly shall be maintained on each resident who receives a limited nursing service. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain LNS records for 3 out of 3 sampled residents (R#2, #6 and #4). The findings include: Record review revealed Resident #2, #6 and #4 required limited nursing services. Further record review revealed the facility failed to provide care and services for the assessment and monitoring of a [redacted] for Residents #2 and #6; failed to assess and monitor the status of an [redacted] tube for Resident #4. However, during review of the facility's LNS records, it was noted that the facility failed to maintain a record of resident's requiring LNS services and the services to be provided, including nursing services provided by a third party. Class III	AN278		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
New Horizon North
8112 NW 74th Terrace
Tamarac, FL 33321

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 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.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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