STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964312	08/13/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bright Horizons Of Coral Springs, Inc	**8664 Nw 1st Street Coral Springs, FL 33071**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0000-Initial Comments

An Assisted Living Facility relicensure survey was conducted on . . . . . Bright Horizons of Coral Springs, had licensure deficiencies found at the time of the visit.

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

Based on observation and interview, it was determined the facility failed to comply with the Resident's Bill of Rights, to ensure residents live in a safe, clean living environment. As evidenced by the facility failure to follow proper hand washing . . . . control practices during medication administration, for 3 out of 5 sampled residents (Residents #2, #4 and #5).

The findings include:

Observation of the Medication pass on . . . . . at 12:30 PM, revealed facility staff approaching the dining table with medications and the Medication Observation Record (MOR) in her hand. The staff was observed to adjust her glasses and hairnet on her head and was then observed to not wash and or sanitize her hands but to proceed to assist Resident # 2 with her medications. The staff was then noted to proceed to assist Resident #4 with self administration of medications and was observed to not wash and or sanitize her hands after assisting Resident #2 with her medications. The staff was observed to provide assistance with self administration of medications for Resident #4 and was then observed assisting Resident #5 with assistance with her self administration of medications without washing and or sanitizing her hands. An interview was conducted withe the Administrator on . . . . at 3:45 PM, she confirmed the findings.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964312	08/13/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bright Horizons Of Coral Springs, Inc	**8664 Nw 1st Street Coral Springs, FL 33071**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

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

Based on record review and interview, the facility failed to ensure that unlicensed staff members who assist residents with self-administration of medications followed required standards of practice, for 3 out of 5 sampled residents (Resident #3 , #4 and #5).

The findings include:

Observation of the medication pass on at 12:20 PM revealed facility staff assisting Resident # 3, #4 and #5 with their medication. The staff member was observed to prepare the medication in front of the residents and then to give the medication to the residents. The staff was observed to not read the medication labels to the resident and was observed to not remain to observe the residents take the medications. An interview was conducted with the Administrator on at 3:33 PM, she confirmed the findings.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Bright Horizons Of Coral Springs, Inc
8664 Nw 1st Street
Coral Springs, FL 33071

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on . 2013 by representatives from this office.

Attached is the provider's copy of the State (5000-3547) 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 (30) 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
XG90

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