STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966234	03/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
New Horizon Of Tamarac	7106 Nw. 84 Street Tamarac, FL 33321	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Relicensure survey was conducted on . . . . . through . . . . . at New Horizon of Tamarac. The facility had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, interview and record review, the facility failed to ensure resident records accurately reflected their condition for 1 of 2 residents sampled for record review(Resident #2). As evidenced by failing to document the assessment and condition of Resident #2's right lower extremity.

The findings include:

Resident #2 was admitted to the facility on . . . . . with diagnoses to include . . . . . and gait disturbance.

On . . . . . at 10:55 AM, an interview was conducted with Resident #2 and it was observed during the interview Resident #2's right lower leg and ankle was viably very . . . . . Resident #2 was unable to explain why or how long his right lower leg and ankle have been . . . . .

On . . . . . at 11:05 AM, an interview was conducted with the facility aide inquiring about the . . . . . of Resident #2's right lower leg and ankle. However, he was unable to explain or give any details about the . . . .

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Review of Resident #2's record revealed documentation on the Resident Observation Log dated [redacted] the resident was evaluated by his physician and the resident's right foot had been [redacted] on and off for a few days. The physician made medication adjustments due to the [redacted]

The next entry in the Resident Observation Log is dated [redacted] documenting the resident was seen by his physician and no adjustments were made to his medications. There was no evidence of documentation regarding the [redacted] of Resident #2's right foot.

The next entry in the Resident Observation Log is dated [redacted] documenting the resident was seen by his physician. There was no evidence of documentation regarding the [redacted] of Resident #2's right foot or if it was still [redacted]

The next entry in the Resident Observation Log is dated [redacted] documenting the resident was seen by his physician stating the physician noted the [redacted] on the resident's right foot was much reduced and no changes were made to the medications.

The next entry in the Resident Observation Log is dated [redacted] documenting the resident was seen by his physician stating no changes were made to the medications and the overall examination went well. There was no evidence of documentation regarding the [redacted] of Resident #2's right foot or if it was still [redacted]

On [redacted] at 2:00 PM, an interview was conducted with the Alternate Administrator who after review of Resident #2's record concurred there was no assessment or documentation related to Resident #2's right leg. The Alternate Administrator stated there should be some kind of assessment documented regarding the status of Resident #2's right leg to see if the [redacted] is getting better or worse.

Resident #2's right leg was observed at 2:04 PM, by the Alternate Administrator who concurred that Resident #2's right lower leg and ankle was very [redacted] During the observation of the Alternate Administrator's observation of Resident #2's right leg, Resident #4 who was sitting across from Resident #2 remarked "his leg is really [redacted] today. It looks worse than it usually does."

On [redacted] at 2:06PM, the Alternate Administrator called the resident's physician regarding the [redacted] of Resident #2's right leg and ankle.

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

Based on observation, interview and record review, the facility failed to a) ensure potential physical were not used as evidenced by half-bed side rails were observed on 7 of 7 resident beds observed; and b) failed to ensure resident's privacy as evidenced by 3 of 3 resident observed had no

The findings include:

a) On at 10:30 AM, an initial facility tour was conducted. To the right of the common living area was a 2 single beds both of which had half-bed side rails. Through an adjoining was another 2 single beds both of which had half-bed side rails. A private observed next to this 1 single bed which had half-bed side rails. On the other side of the house next to the dining was a fourth 2 single beds both of which had half-bed side rails.

On at approximately 10:40 AM, an interview was conducted with the facility aide who confirmed all the beds have side rails, stating that is how they came. An inquiry was made to the aide if any of these residents were on hospice to which he replied 'no'.

On at approximately 11:00 AM, 5 of the 6 resident's records available for review, were reviewed for physician orders and resident/resident representative consent for the use of side rails. The 5 of 6 resident records reviewed revealed no physician orders or resident/resident representative consent.

On at 11:38 AM, a telephone interview was conducted with the Administrator advising her every bed in the facility has side rails to which she replied she was not aware the beds had side rails and she will have her maintenance man go in right away to have them removed.

On at 12:00 PM, the facility maintenance man was observed to be removing the side rails from the 7 resident beds.

b) During the initial facility tour on at 10:30 AM, upon entering the first the common living area, to the left of the observation was made of a doorway with 2 panels of curtains hanging from a curtain rod. The curtains did not go all the way to the floor and the 2 panels were noted to not fully close at the center. The curtains were pulled open slightly to reveal this was the entrance to the resident's this adjoining to the the other side which also had 2 panels of curtains hanging from a curtain rod. This set of curtains also did not go all

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the way to the floor and the 2 panels were noted to not fully close at the center thereby affording the ability to peek through the crack. Four residents shared this one . The single to this observed to also not have a . The curtain panels covering the were made of a sheer see through fabric. The fourth to the dining , which could accommodate 2 residents, also did not have a door to the . The curtain panels covering the opening in this also a sheer see through fabric. Upon entering this was made of a bi-fold door in disrepair and which did not close completely. On the other side of this bi-fold door is the dining .

On at 11:38 AM, a telephone interview was conducted with the Administrator inquiring why the 3 did not have doors to close to afford resident privacy when using the facilities. The Administrator stated the residents kept breaking the bi-fold doors with their walkers so she took the down and put up curtains instead.

On at 2:30 PM, the Alternate Administrator was apprised about the not having doors. She had a surprised look on her face thus a tour was conducted with the Alternate Administrator. Upon entering the first the living observing the curtain panels covering the she stated 'this is not right; there is no privacy; this is a this has to be fixed; there needs to be doors.'

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on interview and record review, the facility failed to ensure medications were signed off on the Medication Observation Record (MOR) as given for 2 of 3 residents reviewed during medication reconciliation (Resident #2 and Resident #3). As evidenced by medications not signed off on the MOR as administered.

The findings include:

1) On at 12:15 PM, the 2014 MORs were reviewed for Resident #2 revealing the eye drops due at 9:00 PM, was not signed off as administered on and . On at 12:20 p.m. an interview was conducted with the medication technician who when asked why the eye drops were not signed off as administered stated the resident was no longer on that medication. Review of the resident's record revealed no physician order to discontinue the eye drops. During an interview with the Assistant Administrator on at 12:22 PM, it was

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discovered the eye drops had run out and had been reordered but not delivered from the pharmacy as yet. The Assistant Administrator was unable to state when the eye drops had been reordered and how long the resident was without the medication. Additionally, a request was made to the medication technician and Assistant Administrator to review the 2014 MORs however the 2014 were not available for review.

Further review of Resident #2's 2014 MOR revealed a physician order for Glucerna liquid supplement to be given at 9:00 AM, and 9:00 PM. The 2014 doses were blank. During the interview with the medication technician on at 12:20 PM, he could not state why those doses were not signed off. Additionally during an interview with the Assistant Administrator on at 12:22 PM, she stated they keep the Glucerna liquid supplement in the cupboard and every day they put some cans in the fridge to get The Assistant Administrator proceeded to the cupboard and pulled out a can of Ensure liquid supplement. The Assistant Administrator could not explain why the supplement was Ensure and not Glucerna, then stated this is what is sent from the pharmacy. She could not explain why the Glucerna was not signed off as given for the month of 2014.

2) On at 12:08 PM, the 2014 MORs were reviewed for Resident #3 revealing on the 6:00 PM, dose of was not signed off as administered. Additionally the 9:00 AM, doses of XL and SR for were not signed off as administered. On at 12:45 PM, an interview was conducted with the medication technician who was unable to explain why the 6:00 PM, dose of was not signed off. He further stated during the interview on at 12:45 PM, he signed off the other 9:00 AM, medications for but must have been distracted and forgot to sign those 3 doses off. He then proceeded to take the MOR and sign off the 6:00 PM, dose of and the Torprol XL and that should have been signed off as administered at 9:00 AM, on signing off those doses at 12:45 PM, in front of this surveyor.

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0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interview, the facility failed to ensure medications were stored in a secure location. As evidenced by observation of medications in plain view in Resident #4's unlocked

The findings include:

On at 10:30 AM, an initial facility tour was conducted. At the end of the short hallway a closed door was observed. While this surveyor was knocking on the door the facility aide walking past stated that is Resident #4's he is out of the facility this morning. The door was unlocked and upon opening the from the doorway observation was made of 2 shelves next to the closet with numerous prescription and nonprescription medication bottles and boxes. Upon review of these medications which were in plain view revealed there were 2 bottles of the same kind of medication, 2 bottles of different medications, one bottle of an medication and one box of an medication in a patch form, one bottle of an one bottle of an anti-s medication, one box of over the counter stomach medication, one bottle of an antiretroviral medication and one bottle of

On at 10:40 AM, the Assistant Administrator was apprised of the medications in Resident #4's an unlocked door and in plain view. The Assistant Administrator stated the resident has a locked box in his he keeps his medications as he does his own medications. Upon entering the resident's Assistant Administrator reiterated the box has to be here somewhere and going in the resident's closet area which did not have a door, picked up a black plastic bin with a lid that was damaged so the lid did not close tightly. There was no observation of a locking device on the box. Observation of the contents of the box revealed more medications to include a bottle of medication, one bottle of anti-s medication, one bottle of an medication, 2 bottles of 2 different medications, a bottle of an antiretroviral medication, and over the counter medications to include a bottle of omega fish oil tablets, a bottle of iron supplements and a bottle of with

During the interview and observations with the Assistant Administrator on at 10:40 AM, she concurred these medications should be locked up and not accessible to the other residents.

On at 11:07 AM, a telephone interview was conducted with the Administrator who stated Resident #4 is independent and administers his own medications. She stated he used to live at their other ALF facility after a hospitalization for a aneurysm and while living at the other

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ALF he was gaining his memory back so they decided to move him to this facility to accommodate for a private . . . . A request was made to the Administrator to review his clinical record and assessment for competency to administer his own medications and the Administrator stated they do not have a record for Resident #4. He is independent and just lives here.

On . . . . . at 4:24 PM, a telephone interview was conducted with Resident #4 inquiring about the medications he is currently taking. He stated the main medication is the Seroquel 400mg every night and he sleeps like a baby. Additionally he stated after his . . . . . aneurysm he was started on medications for . . . . . and . . . . . which he was not on before the . . . . . He further stated the medications that were observed on the shelf in his . . . . . does not take anymore. He just forgot to throw them out. Review of the medications observed on the resident's shelf compared to the ones that were observed in the plastic bin revealed they were the same medications he is taking with the exception of the 2 . . . . . medications.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation, interview and record review, the facility failed to ensure the timely acquisition of a medication was obtained for 1 of 3 residents reviewed for medication reconciliation (Resident #2). As evidenced by eye drops not available for use for Resident #2.

The findings include:

On . . . . . at 12:15 PM, medication reconciliation was done for Resident #2. The resident's medications were observed in the medication cart and upon review of the medications available, in comparison to the medications that were ordered, it was revealed the eye drop medication . . . . . (for the treatment of . . . . . was not available in the medication cart. Review of the . . . . . 2014 Medication Observation Record (MOR) documented Resident #2 to receive . . . . . eye drops, 1 drop in each eye at bedtime. It was noted the eye drops were signed off as administered on . . . and . . . . and the doses due on . . . . and . . . were blank.

On . . . . . at 12:20 PM, an interview was conducted with the medication technician who when asked where the . . . . . eye drops were, stated the resident was taken off the medication and it was a mistake that the medication was signed off as administered on . . . . and . . . . because the resident was not on that medications anymore. Review of the residents record revealed no physician order to discontinue the . . . . . eye drops.

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On [redacted] at 12:22 PM, an interview was conducted with the Assistant Administrator who stated she just spoke with the Administrator via telephone and the Administrator advised her they ran out of the [redacted] eye drops and it has been reordered but it has not been delivered from the pharmacy as yet. The Assistant Administrator was unable to state when the eye drops had been reordered and how long the resident was without the [redacted] medication. Additionally, a request was made to the Medication Technician and Assistant Administrator to review the [redacted] 2014 MORs however they were not available for review.

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on interview, the facility failed to have a staffing schedule readily available for review as evidenced by a staffing schedule not available for review.

The findings include:

On [redacted] at 10:25 AM, an interview was conducted with the facility aide who stated he has been working here for about 2 weeks and he works 3 days in a row live in and someone else works as a live in the other days. However, he was not sure of the person's name.

On [redacted] at approximately 10:30 AM, a telephone interview was conducted with the facility Administrator who stated she is unable to come to the facility due to illness. The Administrator was advised she does not need to be present for the survey however access to resident records, personnel records and staffing schedules will be required. The Administrator stated on [redacted] at approximately 10:30 AM, she is not sure if that is going to be possible because she is the one that has the keys to her office at her other facility but she will see what she can do.

On [redacted] at 10:35 AM, the Assistant Administrator arrived to the facility who stated she does not have access to the Administrator's office at the other facility where all the files are kept. She stated she will see what she can do.

On [redacted] at 11:35 AM, another telephone interview was conducted with the Administrator who stated she keeps all records locked up and everything is at the other home and she is the only one with a key to unlock her office.

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Review of the Certificates Book available for review at the front door revealed a copy of a Designation Form dated designating an On Call Alternate Administrator of the facility documenting she will be on call to act on the Administrator's behalf in the Administrators absence.

On at 11:50 AM, the Alternate Administrator arrived to the facility and stated the Administrator has the only access to staffing schedules, personnel records and resident contracts which are locked in her office. She contacted the Administrator via phone and stated she has an office key and she will go to the other facility and see if the key works.

On at 12:36 PM, the Alternate Administrator arrived back to the facility with the requested personnel records and resident contracts however she stated she does not have access to the staffing schedules and they must be locked up by the Administrator. An inquiry was made to the Alternate Administrator how they know who is scheduled to work or not and the Alternate Administrator stated the staff have their schedules and know when to come into work.

Class III

0162-Records - Resident 58A-5.024(3) FAC

Based on interview and record review, the facility failed to maintain a current up to date record for 2 of 6 residents residing in the facility (Resident #1 and Resident #4). As evidenced by an incomplete record for Resident #1 and no record available for review for Resident #4.

The findings include:

1) On at 10:45 AM, an interview was conducted with Resident #1 who stated he has lived in the facility for month. He stated he was in a nursing home for rehab prior to admission to the ALF and he is currently receiving home health for physical and he uses a walker to aid in ambulation.

Review of the demographic sheet in the resident's record revealed he was admitted to the facility on Review of the Resident Health Assessment 1823 form dated documents his diagnoses to include and history of

Further review of the resident's record revealed no initial assessment by the facility of the status and needs of the resident on admission. There is no initial baseline weight documented. The following admission packet documents are not signed by the resident or his representative to include: Resident

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Right for Self Determination in End of Life Decisions; Informed Consent to Assistance with Medication by Unlicensed Personnel; Policy & Procedure for Facility Elopement/Missing Resident Drill; Acknowledgement for Receipt of Admission Package to include refund policy, house rules, medication storage policy and procedure, elopement policy and policy. There is no photo identification in the record. There is no signed contract with monthly charges in the record.

On at 11:05 AM, an interview was conducted with Resident #1 who stated he did not recall signing a contract when he first came to the facility and he does not know how much rent he is paying.

On at 11:50 AM, a request was made to the Alternate Administrator to retrieve resident contracts to include Resident #1's contract which was locked in the Administrator's office at their other facility.

On at 12:36 PM, the Alternate Administrator arrived back to the facility with the requested resident contracts. However, she stated she was not able to locate a contract for Resident #1.

On at 12:38 pm, the Alternate Administrator contacted the Administrator via telephone who stated Resident #1's contract is with the resident's family and they are waiting on the family to bring it back in as the resident is not allowed to sign anything. The Alternate Administrator and Administrator were unable to provide information on how much Resident #1 was paying per month.

Further review of the information available for review in Resident #1's record revealed no evidence of documentation of a baseline assessment detailing the resident's status such that the Administrator stated during the telephone conversation with the Alternate Administrator on at 12:38 p.m. Resident #1 is not allowed to sign anything.

2) On at 10:30 a.m. an initial facility tour was conducted which revealed inappropriate storage of medications for Resident #4.

On at 11:07 a.m. a telephone interview was conducted with the Administrator who stated Resident #4 is independent and administers his own medications. She stated he used to live at their other ALF facility after a hospitalization for a aneurysm and while living at the other ALF he was gaining his memory back so they decided to move him to this facility to accommodate for a private The Administrator confirmed that they are providing all his meals, doing his laundry, and providing a roof over his head. The Administrator reiterated Resident #4 fends for himself and is independent. A request was made to the Administrator to review his record and assessment for competency to administer his own medications and the Administrator stated they do not have a record

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for Resident #4, he is independent and just lives here.

On [redacted] at 1:55 PM, an interview was conducted with Resident #4 who stated he thinks he has lived her for a few months. He stated he did not sign a contract when he moved from the other ALF to this facility. He stated he had a [redacted] aneurysm and could not remember anything and he was in the hospital for a while before going to the initial ALF. He stated while there his memory was slowly coming back. He stated he does his own medications and confirmed the facility provides his meals, does his laundry and assists with transportation as needed. He stated his goal is to live independently again once he gets stronger.

On [redacted] at 3:55 PM, a telephone interview was conducted with the Administrator who stated when Resident #4 was initially admitted to the other ALF they had an admission record and contract for $2500.00 but then he improved and he was moved to the current ALF as an independent resident. She stated the initial contract is null and void and they now have a written agreement stating that he is now independent status and is paying $2000.00 per month. She further stated Resident #4 is not counted as a resident in the ALF census.
Review of the ALF license reveals the facility is licensed for 6 residents. A head count revealed there were 6 residents living in the home to include Resident #4. During the facility tour it was noted there were 7 beds with 1 bed not occupied.

On [redacted] at 4:24 PM, a telephone interview was conducted with Resident #4 who stated breaking it down he has been with the 2 facilities for about 2 years as he had his [redacted] aneurysm in [redacted] of 2012 and he has lived at this current ALF for about 6 months. Additionally he stated he does not recall signing another agreement when he moved into this facility from the other facility owned by the same people.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
New Horizon Of Tamarac
7106 NW 84 Street
Tamarac, FL 33321

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a state relicensure survey that was conducted on 2014 and 2014 by a representative of 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 days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2014** 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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