STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942812	05/14/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Horizon Bay Vibrant Ret Living 449	730 South Osprey Avenue Sarasota, FL 34236	
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 - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments

These are the results of an unannounced Complaint survey, CCR# 2014002279, conducted on at Horizon Bay Vibrant Retirement Living 449, an Assisted Living facility, located in Sarasota, Florida.

The complaint contained 3 allegations which were substantiated. One of the three was substantiated without a deficiency cited.

The following is a description of the non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on observation, record review, and staff interview, the facility failed to adequately supervise and monitor 1 (Resident #3) of 7 residents after eating lunch on the second floor of the Atrium. This failure contributed to food spillage left on the front of the resident's shirt, the resident spilling water on the floor and hitting himself against the dining without staff intervention.

The findings include:

1. Record review on of the facility's demographic sheet documents Resident #3 was admitted to the facility on Review of the 1823 health assessment dated revealed that it documents Resident #3's medical history and diagnoses which include , femur Under the section entitled, "Physical or sensory limitations," documentation includes "assist x (of) 2 for all transfers..." The assessment documents the resident's or behavioral status as alert, oriented to person only, combative with staff during care. Under the section entitled, service requirements" includes, "received services to improve transfer ability/safety" and under Special precautions, docume risk/combative with care frequently." The resident is non-ambulatory and is a total assist with bathing and dressing. Resident #3 is with eating, total assist with self- care, assisted with toileting and requires 2 people to assist with transfers.

Observation on at 1:16 p.m., of the second flood dining the Atrium confirmed 7 residents seated at dining unattended. A dietary aide was observed cleaning the kitchen and putting food away; however, the residents were not within her sight. Resident #3 was observed seated at a dining and with food spillage on top of his clothing. He grabbed a hold of the dining and began pushing it up against his chest. After hitting the front of his chest 4 times, he stopped pushing the table and took a cup of water in front of him and spilled the water onto the floor beside him. He then put the cup on top of the plate

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nearby and began pushing that back and forth. Water could be observed on the floor next to his wheelchair. He then began pushing the table back and forth in front of him hitting his chest several times. No one was in the assist him.

At 1:23 p.m., Resident Care Associate (RCA) F entered the walked up to another female resident who was sitting at a different dining RCA F was informed of the behavior of Resident #3; however, stated he was the only one on the floor and would help Resident #3 after he "changed the female resident." He said typically there should be two aides assigned to the floor and one goes off to lunch. The aide that went off to lunch had a trainee with her so that's why he came from upstairs to help. They both went to lunch. He removed the female resident from the left Resident #3 alone at the table which was pushed up against his chest and the food spillage remained on the front of his shirt and water on the floor. The resident remained in this condition until 1:32 p.m.

Interview with the Program Director on at 4:30 p.m., confirmed residents should not be left unattended in the dining their meals. She stated the two associates left for lunch at the same time and "should never have done that." She stated it is the facility policy while one assistant is helping residents out of the dining the other needs to remain for those left in the dining monitor.

Class III

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

Based on observation, record review and interview, the facility failed to provide medications in a timely manner for 4 (Residents #2, #4, #5, and #7) of 4 residents reviewed for medications. The facility failed to ensure Resident #5 received food with her according to manufacturer's specifications. The failure to provide medications timely and properly may increase the risk for decline in the physical function and well-being of the residents.

The findings include:

1. Observation during medication administration with the Program Manager (PM), who is an LPN (Licensed Practical Nurse) on at 9:21 a.m., confirmed the medications she was about to administer to Resident #4 were supposed to be given at 8:00 a.m. At 9:21 a.m., the PM removed Cap 240 mg. medication), 5 mg. (anti-depressant), 50 mg. ER medication) tablets and Thera-M from the medication cart and placed the pills inside of a pill cup. After walking to the satellite kitchen to get water, the PM took the medications to Resident #4, handed the medications to the resident and the resident self-administered the medications. She completed the procedure at 9:29 a.m.

At 9:30 a.m., the PM removed the following medications from the medication cart in the medication placed them into a pill cup for Resident #5: 1 mg. (medication used to treat 81 mg., 75 mg. 125 mg. (used to treat ER 25 mg., 20 mg. (used to treat D3 400 IU, and Centrum Silver Chewables (label reads take one tablet daily with food). The nurse confirmed the times for the medications were scheduled for 8:00 a.m. except for the which was scheduled for 9:00 a.m.

The PM exited the locate Resident #5. Resident #5 was observed ambulating in the hallway with her

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4-wheeled walker. She handed the resident her chewable without food, and Resident #5 placed it in her mouth then continued to walk. The nurse walked by her encouraging the resident to eat the After Resident #5 finished chewing, the PM offered the resident her other medications which the resident took independently. The nurse finished the procedure at 9:38 a.m. She could not be sure when the resident had eaten breakfast; she stated breakfast began at 8:00 a.m.

At 9:43 a.m., the PM went back to her cart, removed the following medications for Resident #2 and placed them inside a pill cup: Armour tab 120 mg., Armour tab 30 mg., 25 mg. medication), 75 mg. (anti-platelet medication), 60 mg. (used to treat 0.125 mg. medication), Cap 30 mg. DR (used to treat 25 mg., 1/2 tablet, (anti-ps and Tamulosin 0.4 mg. (used to treat symptoms of enlarged The dosing times of the medications were scheduled for 8:00 a.m.

The PM exited the medication walked to Resident #2's The resident was not in his She then walked to the dining the resident was seated and placed the pill cup in front of him. The PM encouraged the resident to take his medications and after encouragement, the resident took the medications independently.

The PM finished the procedure at 10:00 a.m. After she was finished, the PM was questioned as to why she was assisting with medications and why Residents #4, #5 and #2's medications were given between one-half to one hour late. She stated a staff member called off and she had to cover. She was unaware she failed to give Resident #5 her with food.

Record review for Residents #4, #5, and #2 confirmed the medications were scheduled to be provided at 8:00 a.m. except for the for Resident #5 which was scheduled for 9:00 a.m.

The facility failed to ensure the medications were provided in a timely manner. The PM failed to ensure Resident #5 was provided food according to manufacturer's specification for the supplement.

2. On at 9:59 a.m., Staff D stated that she "heard" Resident #7 was recently given her medications 3 hours late.

In an interview with the HWD (Health and Wellness Director) on at 6:40 p.m., she stated the medication aide was going to be late. They didn't know how late. Once she (medication aide) got to the facility, the aide thought the medications were out of the scope of time to be given and she started crying. The HWD stated the aide got to the facility at about 9:30 a.m., and based on the directive of the program manager, who is a LPN (Licensed Practical Nurse), the aide was instructed to provide the medications. The HWD stated they were still going through the breakfast meal so the timing wasn't 3 hours late, the timing was approximately ½ hour late. When asked when this occurred, she could not be specific but thought it was "just last week."

Review of the 2014 MOR (Medication Observation Record) revealed that it documents the following medications scheduled for 8:00 a.m., to be provided to Resident #7: Ointment, 120 mg., 125 mg. and Oxcarbazepin Suspension 150 mg. (anticonvulsant and mood stabilizer). The MOR documents the medications were signed off as provided at the 8:00 a.m. dosing times.

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The HWD was interviewed on at 6:45 p.m. She confirmed the medications were not provided at 8:00 a.m. When asked why there was no evidence of the exact times the medications were provided, she stated, "I didn't think she (medication tech) needed to document anything because she was directed by her nurse to go ahead and give the medications past their time frame and they weren ' t really too late. "

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on observation, record review, and interview, the facility failed to ensure certified or licensed staff were applying and removing anti-embolic compression stockings for 1 (Resident #1) of 2 residents who were ordered to wear the specialty stockings. The failure to ensure certified or licensed staff are applying and removing anti-embolic compression stockings may impact the adequacy of flow through the resident's lower extremities and increase the potential for clots to develop.

The findings include:

1. During the entrance conference with the Executive Director and Health and Wellness Director (HWD) on at 9:00 a.m., the HWD was asked to provide a list of residents who wear compression stockings. The HWD indicated there is no one in the facility wearing compression stockings.

During the tour of the Bayou section of the facility on between 9:30 a.m. and 11:30 a.m., Resident #1 was observed in her wheelchair being assisted by Staff C toward the main dining the first floor. Resident #1 stated she was going to breakfast. The resident was observed with knee high support compression stockings to the both of her lower extremities. Resident #1 confirmed she wears the stockings to "help with the circulation in her legs." When asked who puts her stockings on, she pointed to Staff C and stated, "Well, I think she does." Staff C confirmed they help Resident #1 put her stockings on.

Record review on of the demographic sheet documents Resident #1 was admitted to the facility on Review of the 1823 health assessment dated documents Resident #1's medical history and diagnoses which include , chronic kidney and No nursing, treatments, or services are required. Resident #4 is independent with dressing, eating, self- care, toileting and transfers and assisted with ambulation and supervised for bathing.

Review of the care physician's orders dated documents the following: hose compression lower legs, (patient) to obtain compression stockings and wear daily". There were no other instructions as to the frequency or duration of the use of the stockings.

Interview with Staff C and Staff D on at 11:29 a.m., confirmed they put the resident's stockings on in the morning and then someone takes them off at night.

Interview with the HWD on at 3:50 p.m., confirmed neither Staff C or D were certified nursing assistants and she had no idea Resident #1 was wearing the hose or the associates were putting them on.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Horizon Bay Vibrant Ret Living 449
730 South Osprey Avenue
Sarasota, FL 34236

Dear Administrator:

Re: CCR #2014002279

This letter reports the findings of a complaint survey that was conducted on 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 surveyor. Should you have any questions please call this ofice at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

HW:ss
Enclosure: State Form

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