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	AL11965994	10/27/2014
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List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
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 - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin 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 - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0086 - 58a-5.0191(9) Fac - Training - Adrd S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - [redacted] S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Relicensure Survey with Limited Nursing Services (LNS) was conducted on [redacted] at New Horizon North Assisted Living Facility. The facility had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on observation, interview and record review, the facility failed to ensure Resident Health Assessments (AHCA Form 1823) accurately reflected the condition of 4 of 5 resident records reviewed (Resident #1, Resident #3, Resident #4 and Resident #5). As evidenced by incomplete assessments prepared by health care examiner.

The findings include:

1) Resident #1 was admitted to the facility on [redacted] with diagnoses to include [redacted] and [redacted] Review of the 1823 Health Assessment dated [redacted] reveals

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no documentation of Special Diet Instructions.

2)Resident #3 was admitted to the facility on . . . . . with diagnoses to include . . . . . and . . . . . Review of the 1823 Health Assessment revealed it was not dated; Special Diet Instructions is blank; Can needs be met in an assisted living facility is not completed; and assistance with medications is not completed. On at 1:00 p.m., an interview was conducted with the Administrator who stated the resident had a . . . . on . . . . . and was sent to the hospital and on she returned to the facility with a new 1823 form completed by the hospital physician. The Administrator concurred the 1823 form should have been addressed to include the missing information.

3) Resident #4 was admitted to the facility on . . . . . Review of the 1823 Health Assessment revealed it was not dated; the address and telephone number of the examiner is not completed; whether the resident requires assistance with medications is not completed; service requirements is not completed; communicable . . . . . status,poses a danger to self or others and requires 24 hour nursing or care is not completed. The health examiner documents the resident is total assist with activities of daily living and the resident in nonambulatory. Further review of the the assessment documents under Medical History and Diagnoses reveals the only diagnosis documented is Parkinson's . . . . . Review of the list of current medications as documented on the health assessment includes in addition to medications for Parkinson's , the resident is also prescribed medications for . . . . . conditions, . . pain and .

On at 11:45 a.m., Resident #4 was observed to be assisted out of the lounge chair by the aide and ambulate with a walker to the dining . Additionally Resident #4 was observed to feed himself without assistance.

On . . . . . at 12:50 p.m., an interview conducted was conducted with the Administrator who stated the resident was admitted from the hospital and it looks like the hospital physician did not entirely complete the form.

4) Resident #5 was admitted to the facility on . . . . . with diagnoses to include . . and gait disturbance. Review of the resident's record revealed the only 1823 Health Assessment available for review was completed by the physician on with no documentation under the . . service requirements and Special Precautions sections.

Class III

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0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on observation, interview and record review, the facility failed to ensure Resident Health Assessments (AHCA Form 1823) reflected changes in condition, for 2 of 5 resident records reviewed (Resident #2 and Resident #4). As evidenced by the 1823 Health Assessments not being updated to reflect a decline in condition for Resident #2 and admission to hospice care for Resident #4.

The findings include:

1) Resident #2 was admitted to the facility on with diagnoses to include and Review of the 1823 Health Assessment in the resident's record dated revealed under Activities of Daily Living the resident is documented as being independent with ambulation, eating, transferring, dressing and toileting.
On at 9:30 a.m., Resident #2 was observed sitting in a lounge chair in the living At 11:50 a.m. the resident, still seated in the lounge chair, was advised by the aide that it is time for lunch at which point the aide went up to the resident and physically assisted the resident out of the chair by putting her arms under the resident's arm pits and assisted with hoisting her out of the chair. The aide was then observed to hold onto the resident's left arm and guide the resident to the dining
The resident was observed to take tiny steps at a time and was hanging on to the aides arm. Once at the dining the lunch meal, consisting of soup, sandwich and canned pears, was placed in front of the resident. However, she made no attempt to pick up a utensil and start eating. At 12:00 p.m. , the resident picked up half of a sandwich, took a small bite and placed it back on the plate. At 12:15 p.m., the aide was observed to sit next to the resident and start feeding her soup, sandwich and pears until the meal was consumed.
On at 2:00 p.m., an interview was conducted with the aide who stated the resident does require assistance and encouragement at meals and does require assistance with getting up and ambulating as she tends to lean to the side.

2) Resident #4 was admitted to the facility on with a diagnosis of Parkinson's Review of the resident's record revealed he was admitted to the facility after a hospitalization and was admitted under hospice care on with a diagnosis of while hospitalized. Review of the 1823 Health Assessment in the resident's record, not dated and with a blank service requirements does not document the resident is currently under hospice care.

On at 12:50 p.m. , an interview was conducted with the Administrator who stated Resident #4 lived at their sister facility and he was admitted to the hospital. She stated he moved here on as his condition was declining and he required more assistance. She stated he moved to this facility from

the hospital and it looks like the hospital physician did not entirely complete the form. The Administrator concurred the 1823 Health Assessment should reflect the resident is currently under hospice care.

Class III

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 5 resident records reviewed (Resident #4). As evidenced by no documentation of status for Resident #4.

The findings include:

Resident #4 was admitted to the facility on with a diagnosis of Parkinson's Review of the Resident Observation Log revealed documentation dated he was 'admitted to the facility from the hospital. After assessing resident an unhealed was noticed on his left hip bone.' The next and the only other entry in the Observation Log is dated with no further documentation or assessment of the to the left hip bone.

On at 11:30 a.m., an interview was conducted with the Administrator inquiring about the assessment of the unhealed to the resident's left hip to which she replied it is just redness and not open. A request was made to observe the

On at 11:45 a.m. the resident was assisted by the aide to the his walker and in the presence of the Administrator and aide, observation was made of the resident's left hip area to reveal a patch of skin, approximate size of a golf ball (Resident #4 is dark skinned) with a red, excoriated and open area, the approximate size of a dime, in the center of the patch. After the Administrator made an observation of the resident's left hip area she had a startled look on her face and had no comment.

Class III

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

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Based on observation, interview and record review, the facility failed to ensure that bed side-rails were only used when ordered by the health care provider on an annual basis for 2 of 3 resident beds observed with side rails, Resident #2 and Resident #5, as evidenced by no current orders for bed side-rails available for review for Residents #2 and #5.

The findings include:

1) Resident #2 was admitted to the facility on [redacted] with diagnoses to include [redacted] and [redacted]

On [redacted] at 9:30 a.m. during the facility tour, half bed side rails were observed attached to Resident #2's bed. Observation of Resident #2 throughout the survey revealed she requires [redacted] with activities of daily living.
Review of the resident's record revealed a physician order dated [redacted] for half bed rails and a consent dated [redacted] signed by the resident's health care surrogate. A annual physician order for the bed rails was not available for review for 2013 or 2014.

2) Resident #5 was admitted to the facility on [redacted] with diagnoses to include [redacted] and gait disturbance.
On [redacted] at 9:35 a.m. during the facility tour, half bed side rails were observed attached to Resident #5's bed. Review of Resident #5's 1823 Health Assessment revealed he requires assistance with activities of daily living.
Review of the resident's record revealed a consent dated [redacted] for half bed rails signed by the resident's daughter. Further review of the resident's record revealed no physician order for the bed rails for 2012, 2013 or 2014.

On [redacted] at approximately 2:00 p.m. an interview was conducted with the Administrator who confirmed there were no annual orders obtained for the bed side rails.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, interview and record review , the facility failed to ensure residents were cognizant of the medications they are receiving for 1 of 1 residents observed during medication pass, Resident #4; and failed to ensure the unlicensed staff member, Staff member 'A', assisting with the administration of medications was cognizant of the purpose of the medications he was assisting Resident #4 with to be

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able to identify any side effects or reactions that may be caused by the medication.

The findings include:

On [redacted] at 11:50 a.m. Staff member 'A' was observed assisting Resident #4, with the Administrator present, with his 12 noon medication, [redacted] used for a diagnosis of Parkinson's [redacted]. Staff member 'A' was observed to pop the pill out of the [redacted] pack into a medication cup, hand the medication cup to the resident who put the pill in his mouth and took it. Staff member 'A' was not observed to explain what the medication was for. An inquiry was made to Resident #4 if he knew what medication he just took and the resident was not able to respond and shrugged his shoulders. On [redacted] at 12:00 p.m. Staff member 'A' was asked what the pill Resident #4 just took was for. Staff member 'A' was then observed to look at the medication [redacted] pack, front and back and back and front and would not provide an answer. An inquiry was made again to Staff member 'A' what the [redacted] was used for and he proceeded to look at the Medication Observation Record (MOR) and pointing to the medication slot on the MOR which documented the physicians name, stated the medication is used for 'physician's name' as he was pointing at the physician name and not the name of the medication. This surveyor brought to Staff member 'A's attention that he was pointing to the physician name and the 'physician name' is not a diagnosis for the medication. Staff member 'A' then stated 'the medication is used for sickness.' The Administrator was then observed to look at the MOR and pointed out to Staff member 'A' the diagnosis is documented on the MOR above the staff initial signing boxes and clearly documents the [redacted] is used for Parkinson's [redacted].

Review of the personnel record for Staff member 'A' revealed he completed a 4 hour Assistance with Medication training on [redacted].

Class III

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 the facility office area; medications stored in an unlocked box; and the medication cart keys were stored in plain view above the medication cart.

On [redacted] at 9:15 a.m., the facility was entered and a work space was supplied in the office area behind unlocked bifold louver doors off the living [redacted] to the right of the front door. Six residents were observed seated in the living [redacted]. Upon entering the office, observation was made of a stack of

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medications laying out in plain view on top of the desk. Eleven medications were counted to include an high medications, a vial of and an medication.

On at 10:00 a.m., an interview was conducted with the facility office helper who stated the medications belong to a resident that was just readmitted on Saturday and the medications are being stored on the desk for the Administrator to review when she gets in today, Monday. She further stated the resident takes her own medications but they store them in the office for her. A request was made to review the resident's record but the office helper stated they do not have a record for the resident as she just lives here independently and pays rent and the facility does not do anything for her.

On at 12:25 p.m.,an interview was conducted with the resident who stores her medications in the office and she confirmed that she does her own medications and tests her sugar and administers her own once a day. The resident was observed to be alert and oriented and fully ambulatory without any assistive devices.

On at 11:50 a.m. , a medication pass observation was made with the medication technician. He proceeded to retrieve the medication cart keys that were hanging on a hook on the wall behind the medication cart which is stored in the dining plain view of all residents, visitors and staff. After the medication was retrieved from the medication cart he proceeded to lock the cart and replace the medication cart keys back on the hook on the wall behind the medication cart.

On at approximately 3:00 p.m. an interview was conducted with the Administrator inquiring why the medication cart keys are stored in plain view and she stated it is so they can have easy access to the keys as sometimes the staff takes the keys home with them and she has to change the locks. The Administrator further stated her residents do not ambulate without assistance so they could never get the keys and get into the medication cart. The Administrator was reminded that there are third party vendors, family and the woman who is living here that is fully ambulatory, could gain access to the medications in the medication cart. An inquiry was made to the Administrator of the woman who was also living here and not considered part of her census and the Administrator and office helper stated they keep her medications in a box in this office and the office helper proceeded to take a gray box from under the desk, placed it on the desk and opened it up without having to unlock it first. The Administrator and office helper confirmed the box closes but it does not lock.

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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 2 residents reviewed for medication reconciliation, Resident #1. As evidenced by eye drops not available for use for Resident #1.

The findings include:
On [redacted] at 1:00 p.m., medication reconciliation was done for Resident #1 to reveal Refresh eye drops not available in the medication cart. Review of the [redacted] 2014 Medication Observation Record (MOR) revealed documentation of the Refresh eye drops with a physician order dated [redacted] to instill 1 drop in both eyes 4 times daily was not being administered since [redacted] Further review of the MOR revealed from [redacted] through [redacted] a circle was drawn in the slot for each administration time at 8 AM, 12 PM, 5 PM and 8 PM. On [redacted] at 1:03 p.m. , an interview was conducted with the medication technician who confirmed that when they put a circle at the administration time that means the medication is not available. Additionally, she stated they are having a hard time with the insurance company and are waiting on the refill. She stated they contacted the doctor and the drops should be delivered this evening.

Further review of the [redacted] 2014 MOR revealed an additional eye drop, [redacted] for the eyes) was also ordered on [redacted] to instill 1 drop in both eyes 4 times daily. The [redacted] is documented as being administered from [redacted] through [redacted] and from [redacted] through [redacted] Review of the MOR revealed a circle was drawn in the slot for each of the 4 administration times. Observation of the box containing the [redacted] revealed it was refilled on [redacted] During the interview with the medication technician on [redacted] at 1:03 p.m. , she stated the eye drops were not administered because they were not available as they were waiting on the insurance company to approve the drops as they ran out before the insurance company would authorize further refills. An inquiry was made if the eye doctor was made aware the 2 eye drop medications were not available and she stated she was not sure if they called the doctor.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on interview and personnel record review, the facility failed to ensure that direct care staff members had the required in-service trainings, for 2 of 3 direct care staff records reviewed (Staff member A and Staff member C.)

The findings include:

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During a review of the personnel records it was noted that Staff member A, a direct care staff, hire date of , did not have the following required in-service trainings within 30 days of the date of hire: Elopement response policies and procedures; Emergency Procedures; Reporting major incidents; Resident rights in an assisted living facility; and Recognizing and reporting resident , neglect, and

During a review of the personnel records it was noted staff member C, a direct care staff, hire date of , did not have the following required in-service trainings within 30 days of hire; Control; Elopement response policies and procedures; Emergency Procedures; Resident rights in an assisted living facility; and Recognizing and reporting resident , neglect, and

On at approximately 3:00 p.m., an interview was conducted with the Administrator and no additional information was provided.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on interview and personnel record review, the facility failed to ensure that 1 of 3 direct care staff members, (Staff member B) who provides assistance with self-administered medications, had the required annual 2 hour continuing education training.

The findings include:
Review of the personnel record for Staff member C, date of hire revealed the last 2 hour continuing education training for assistance with self-administered medications was dated

On at approximately 12:30 p.m., an interview was conducted with Staff member B who stated she does assist residents with the self-administration of medications.

On at approximately 3:00 p.m., an interview was conducted with the Administrator who stated she was sure Staff member B had the 2 hour medication training however was unable to produce the information requested.

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0086-Training - ADRD 58A-5.0191(9) FAC
Based on interview and personnel record review, the facility failed to ensure that 1 of 3 direct care staff members, (Staff member C) had the required 4 hour and Related (ADRD) training requirements within 3 months of hire.

The findings include:
Review of Staff member C's personnel record revealed a hire date of . Further review revealed she did not have evidence of the 4 hour ADRD training in her record.

Review of 3 of 5 Resident records revealed Resident #1, #2 and #3 had a diagnosis of .

On at approximately 3:00 p.m. an interview was conducted with the Administrator who had no additional information to provide.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on interview and personnel record review, the facility failed to ensure that a direct care staff member had the required 1 hour in-service for Training for 1 of 3 direct care staff personnel records reviewed (Staff member A).

The findings include:

Review of the personnel record for Staff member A revealed a date of hire Further review revealed he did not have the required 1 hour training within 30 days of hire.
On at approximately 1:00 p.m., an interview was conducted with Staff member A and an inquiry was made to explain what means. Staff member A was initially unable to provide an explanation and then stated he 'thinks that means they are sick'.

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0162-Records - Resident 58A-5.024(3) FAC
Based on interview and record review, the facility failed to ensure weights were documented for 1 of 5 resident records reviewed (Resident #4).

The findings include:

Resident #4 was admitted to the facility on with a diagnosis of Parkinson's . Review of the medication list reveals the resident is taking medications for Parkinson's conditions, pain and
Review of the Resident Observation Log revealed documentation dated the resident was admitted to the facility from the hospital.
Further review of the resident's record revealed a weight log with no base line weight documented from the date of admission nor any other documentation of the resident's weight.
On at approximately 3:45 p.m. an interview was conducted with the Administrator who concurred they should at the least have a base line weight documented.

Class III

0167-Resident Contracts 58A-5.025 FAC
Based on interview and record review, the facility failed to ensure a resident's contract was executed and signed by the resident's legal representative for 1 of 2 resident contracts reviewed (Resident #4). As evidenced by review of the contract dated is not signed by the resident's legal representative.

The findings include:

Resident #4 was admitted to the facility on with a diagnosis of Parkinson's . Review of the resident's contract dated revealed all admission paper work was not signed to include contract acknowledgment, resident rights/end of life decisions, grievance policy, medication availability, informed consent to assist with medications with unlicensed personnel, resident house rules, elopement and resident bill of rights. On at 1:55 p.m., an interview was conducted with the Administrator who stated the resident was residing at their sister facility and from there he was sent to the hospital. She stated his current condition is such that he requires more care and is declining so he was transferred to this facility to be able to accommodate his needs. She further stated the responsible party, the resident's son, was on a cruise so they could not get the paper work signed. She stated they should have addressed this earlier and will contact the son as it has been a month and he should be back

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from his trip by now.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

RE: Relicensure Survey with Limited Nursing Services

Dear Administrator:

This letter reports the findings of a state Relicensure 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 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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